Exhibit (14)

D H E C

PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

April 26, 2011

Ronald A. Malone, Chairman & CEO
Capital Care Resources of S. C., Inc.
C/O Selece Beasley, Compliance Director
Gentiva Health Services
3350 Riverwood Parkway, Suite 1400
Atlanta, GA. 30339

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
91 7108 2133 3933 7190 9984

Re: Carolina Home Health Care, License Number: HHA-0154

Dear Mr. Malone:

Please find enclosed an executed copy of our April 20, 2011 Consent Order and Agreement with Carolina Home Health Care.

By letter dated February 2, 2011, we notified you of a staff decision to impose an $8,700 monetary penalty against Carolina Home Health Care for violations of Standards for Licensing Home Health Agencies: 25A S.C. Code Ann. Regs. 61-77 (Supp. 2009). On February 24, 2011 we were able to come to a mutual agreement for resolving this matter. The Consent Order and Agreement assessed a civil penalty in the amount of $8,700. A term of this Consent Order and Agreement required Carolina Home Health Care to pay the Department the $8,700 monetary penalty within 30 days of the execution of the Consent Order and Agreement.

This letter also acknowledges payment of the $8,700 assessed monetary penalty on April 12, 2011.

Please ensure that Carolina Home Health Care is operated in substantial compliance with R.61-77 and in compliance with the terms of the April 20, 2011 executed Consent Order and Agreement.

Should you have any questions, please contact me at (803) 545-4370.

Sincerely,

Nancy E. Maertens

Nancy E. Maertens, Director
Division of Health Licensing

NEM:jer:sme

Enclosures

cc: Pamela M. Dukes, DHEC
Melinda W. Bradshaw, DHEC
Dennis L. Gibbs, DHEC
Gwen Thompson, DHEC
Vickie McGahee, SCDMH
Mildred Washington, SCDSS
Kevin Varn, SCDHHS
Chris Stephens, DHEC
Ashley Biggers, Esquire, DHEC Attorney
Kristin L. Pawlowski, Esquire, DHEC Attorney
Ann Dalton, SCDDSN
Cindy Alewine, Alzheimer's Assoc.
Lee Ann Bundrick, SCBLTHCA
Brenda Hylleman, SCDSS
Pete Houchins, Administrator, Carolina Home Health Care

STATE OF SOUTH CAROLINA
BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

In RE: **Capital Care Resources of South Carolina, Inc.**
Carolina Home Health Care
810 Dutch Square Boulevard, Suite 206
Columbia, South Carolina 29210-7318

Consent Order and Agreement
CO-HL-03-2011

FINDINGS OF FACT:

1. Capital Care Resources of South Carolina, Inc. is the holder of a license to operate Carolina Home Health Care (Facility), a home health agency licensed by the South Carolina Department of Health and Environmental Control (Department), pursuant to S.C. Code Ann. § 44-7-110 et seq., State Certification of Need and Health Facility Licensure Act (2002 and Supp. 2010); S.C. Code Ann. § 44-69-10 et seq., Licensure of Home Health Agencies Act (2002); and 25 S.C. Code Ann. Regs. 61-77, Standards for Licensing Home Health Agencies (Supp. 2010). Facility is located at 810 Dutch Square Boulevard, Suite 206, Columbia, South Carolina, and is licensed to provide home health services in Lexington and Richland Counties.

2. On January 6, 2011, Department representatives visited Facility to conduct a complaint investigation regarding the care of a patient. As a result, the following violations of Reg. 61-77 were observed and cited:

A. § 102.B.- At the time of the inspection, the facility did not have a copy of the licensing standards available for reference.

B. § 501.B.-

i. In one of seven personnel records reviewed, performance evaluations of a facility staff were not conducted within the time frame established by facility policy.
ii. In one of seven personnel records reviewed, there was no documentation available for review that a facility staff had a performance evaluation within the time frame established by facility policy.
iii. In four of seven staff records reviewed, there was no documentation of annual training (e.g., OSHA, Disaster Plans, Incident Reporting).

iv. According to in-service training documentation, staff had been instructed to document assessments contrary to facility policy.

C. § 701.A.- For a patient's record reviewed, the safe and effective manner for treatment was questionable, as there were several documented incidents of roaches in the bed with the patient and on the bedside table beside the patient.

D. § 701.B.-

i. For one of one patient record reviewed, there were several instances where the patient's wound was not measured per facility policy.

ii. For one of one patient record reviewed, established facility policy was not followed in that vital signs were not documented or were only partially documented at every visit.

E. § 1001.A.-

i. In two of seven personnel records reviewed, it could not be determined if the Orientation Phase I, II and III Checklist for a staff person had been completed, as evidenced by signature of the employee or manager.

ii. For a patient's record reviewed, adequate staff was not available for the patient's needs as evidenced by the last visit on November 9, 2010. The patient's treatment plan required weekly visits. Resignation of the primary nurse was not followed up on and the patient did not have future visits. The patient expired on December 3, 2010.

F. §1002.B.1.- In one of seven personnel records reviewed, there was no documentation of an annual TB test. The last documented TB test for this staff person was dated September 26, 2009.

G. § 1301.A.- At the time of the inspection, there was no documentation available for review of a written agreement with a wound center; however, it was documented in nurse's notes that the patient was receiving service from a wound center. When staff was asked how often and by whom, the reply was, "I don't know, her husband took her."

3. By letter dated February 2, 2011, the Department notified Facility that it was considering the imposition of a $8,700 monetary penalty for the above-referenced

violations. The Department requested that Facility attend an enforcement conference to discuss the violations. The parties met on February 24, 2011.

CONCLUSIONS OF LAW:

1. The Department is the agency of the State of South Carolina responsible for establishing and enforcing basic standards for licensure, maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State. S.C. Code Ann. § 44-7-250 (2002). The Department is charged with licensing and regulating home health agencies in this State. S.C. Code Ann. §§ 44-7-260(A)(10), 44-69-30 and -60 (2002); 25 S.C. Code Ann. Regs. 61-77 (Supp. 2010).

2. The Department is authorized to make inspections and investigations of licensed facilities as considered necessary. S.C. Code Ann. §§ 44-7-150(1) and 44-69-70 (2002); 25 S.C. Code Ann. Regs. 61-77 § 201 (Supp. 2010).

3. The Department may take enforcement action against a home health agency for violating a provision of the Regulation. S.C. Code Ann. §§ 44-7-320(A)(1)(a) (2002 and Supp. 2010), 44-69-60 (2002); 25 S.C. Code Ann. Regs. 61-77 § 301 (Supp. 2010).

4. Based upon the foregoing facts, the Department finds Facility in violation of Reg. 61-77 as follows:

A. Facility violated § 102.B. by failing to have a copy of the licensing standards available for reference. This is a Class III violation and carries no penalty for a first occurrence.

B. Facility violated § 501.B. by failing to adequately train staff and follow Facility's policies related to patient assessments and staff evaluations. This is a Class II violation and carries a maximum penalty of $500 for a first occurrence.

C. Facility violated § 701.A. by Facility staff failing to assure for the safe and effective treatment of a patient. This is a Class I violation and carries a maximum penalty of $1,000 for a first occurrence.

D. Facility violated § 701.B. by failing to document wound measurements and the vital signs of a patient on numerous occasions, thus failing to provide nursing and other therapeutic services in a safe and effective manner. This is a Class I violation and carries a maximum penalty of $1000 for a first occurrence.

E. Facility violated § 1001.A. by failing to properly orient a staff person and provide adequate staff to meet patient needs. This is a Class I

violation and carries a maximum penalty of $1,000 for a first occurrence.

F. Facility violated § 1002.B.1. by failing to maintain documentation of an annual TB test. This is a Class II violation and carries a maximum penalty of $500 for a first occurrence.

G. Facility violated § 1301.A. by failing to maintain a written agreement with a wound center. This is a Class III violation and carries no penalty for a first occurrence.

NOW THEREFORE IT IS ORDERED with the consent of Carolina Home Health Care:

1. Facility agrees to the imposition of an $8,700 monetary penalty by the Department. Facility will make payment of the $8,700 assessed penalty by certified check or money order payable to the S.C. Department of Health and Environmental Control within 30 days of execution of this Consent Order and Agreement

Payment shall be sent to the following address:

Attention: Nancy Maertens
Division of Health Licensing
S.C. Department of Health and Environmental Control
2600 Bull Street
Columbia, S.C. 29201

If payment is late for any reason not otherwise approved by the Department, the Department may assess additional penalties, up to and including revocation of Facility's license.

2. Facility agrees to initiate action to correct the violations that initiated this enforcement conference as well as to ensure that all violations of 25 S.C. Code Ann. Regs. 61-77 (Supp. 2010) are not repeated.

3. Facility acknowledges that Reg. 61-77 § 201 permits inspections to be conducted as deemed appropriate by the Department. Facility understands that representative(s) of the Department may conduct periodic inspections of the Facility from time to time to determine if Facility is operating in substantial compliance with Reg. 61-77, and that the Department may also conduct investigations of any complaints it receives.

4. It is further agreed that if Facility is found to be in substantial non-compliance with Reg. 61-77 or this Consent Order and Agreement following execution, as determined by the Department, the Department may assess an additional penalty.

5. This Consent Order and Agreement contains the entire agreement between the parties with respect to the resolution and settlement of the matters set forth herein. The parties are not relying upon any representations, promises, understandings, or agreements except as expressly set forth within this Consent Order and Agreement.

6. The parties understand that this Consent Order and Agreement governs only the liability to the Department for civil sanctions arising from the matters set forth herein.

FOR THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL BY:

C. Earl Hunter, Commissioner
S.C. Department of Health and Environmental Control — Date: 4-20-11

WE CONSENT:

Pamela M. Dukes
Deputy Commissioner for Health Regulation — Date: 4/14/11

For Dennis L. Gibbs, Chief
Bureau of Health Facilities Regulations — Date: April 14, 2011

Nancy E. Maertens, Director
Division of Health Licensing — Date: April 13, 2011

Reviewed by:

Ashley C. Biggers
Chief Counsel for Health Regulation — Date: 4/14/11

FOR CAPITAL CARE RESOURCES OF SOUTH CAROLINA, INC.

Ronald A. Malone, Chairman & CEO
Capital Care Resources of South Carolina, Inc. — Date: April 4, 2011

Pete Houchins, Administrator
Carolina Home Health Care — Date: 4/8/11

Exhibit (15)

112TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
112–24

STAFF REPORT ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD

PREPARED BY THE STAFF OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

SEPTEMBER 2011

Printed for the use of the Committee on Finance

STAFF REPORT ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD

112TH CONGRESS
1st Session

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S. PRT.
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SEPTEMBER 2011

Printed for the use of the Committee on Finance

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CONTENTS

Introduction

The United States Senate Committee on Finance (Committee) has a duty to conduct oversight of the programs in its jurisdiction, including Medicare and Medicaid. This duty includes the responsibility to monitor payments made by the Centers for Medicare and Medicaid Services (CMS) for home health services in order to protect taxpayer dollars from waste, fraud, and abuse.

In May 2010, the Committee initiated an inquiry into home health therapy practices at Amedisys, LHC Group, Gentiva, and Almost Family, the four largest publicly traded home health companies, after a *Wall Street Journal* analysis of therapy utilization patterns at those four companies suggested they were taking advantage of the Medicare therapy payment system by providing medically unnecessary patient care.[1]

The Committee staff reviewed documents provided by Amedisys, LHC Group, Gentiva, and Almost Family. All companies cooperated with the Committee's investigation.

In its review, the Committee found Amedisys, LHC Group, and Gentiva encouraged therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns:

- Therapy visit records for each company showed concentrated numbers of therapy visits at or just above the point at which a "bonus" payment was triggered in the prospective payment system (PPS).
- Internal documents from Amedisys show that, prior to the 2008 CMS therapy payment changes, managers were encouraged to meet the 10-visit therapy threshold.
- An "A-Team" set up by Amedisys corporate management developed therapy programs after the release of the 2008 proposed PPS changes to target the most profitable Medicare therapy treatment patterns, including adding therapy visits to clinical tracks that previously did not involve therapy.
- Amedisys pressured therapists and regional managers to adhere to new clinical guidelines developed to maximize Medicare reimbursements.
- Internal e-mails identify top LHC Group managers, including the company's CEO, who instructed employees to increase the number of therapy visits provided in order to increase case mix, a measurement of patient acuity, and revenue.
- Internal documents show that Gentiva developed a competitive ranking system for their management aimed at driving therapy visit patterns toward more profitable thresholds.

[1] Barbara Martinez, "Home Care Yields Medicare Bounty," *Wall Street Journal*, April 26, 2010; Barbara Martinez, "Senators Question In-Home Caregivers," *Wall Street Journal*, May 13, 2010.

- Internal documents show that Gentiva management discussed increasing therapy visits and expanding specialty programs to increase revenue.

The home health therapy practices identified at Amedisys, LHC Group, and Gentiva at best represent abuses of the Medicare home health program. At worst, they may be examples of for-profit companies defrauding the Medicare home health program at the expense of taxpayers.

Background on Therapy Thresholds

The Balanced Budget Act of 1997 (BBA) changed the way Medicare paid for home health services by requiring the implementation of a home health prospective payment system (PPS). Prior to the establishment of PPS, Medicare paid on a cost-based reimbursement system, in which Medicare paid separately for items and services furnished by each home health agency.[2]

In creating the PPS, the Centers for Medicare and Medicaid Services (CMS) established a basic unit of payment for home health services in which home health agencies would receive payment for a 60-day episode of care. This single payment was intended to cover the skilled care needs of individuals who were restricted to their homes for a 60-day period.[3] These services included nursing care; physical, occupational, and speech therapy; medical social work; home health aide services; and certain routine medical supplies.[4]

CMS also developed a patient classification system to adjust payments, also known as a "case-mix adjustment," in the home health PPS based on each patient's health characteristics and use of services. The patient classification system originally consisted of 80 Home Health Resource Groups (HHRGs). Home health agencies would determine each patient's health characteristics using the Outcome and Assessment Information Set (OASIS) and each patient would be assigned to an HHRG based on that assessment. Figure 1 outlines the pre-2008 clinical, functional, and service metrics from OASIS used to determine each patient's HHRG.[5]

---

[2] Office of Inspector General, "Medicare Program; Prospective Payment System for Hospital Outpatient Services, Background," *Federal Register* 65:68 (7 April 2000), pp. 18434, 18436.

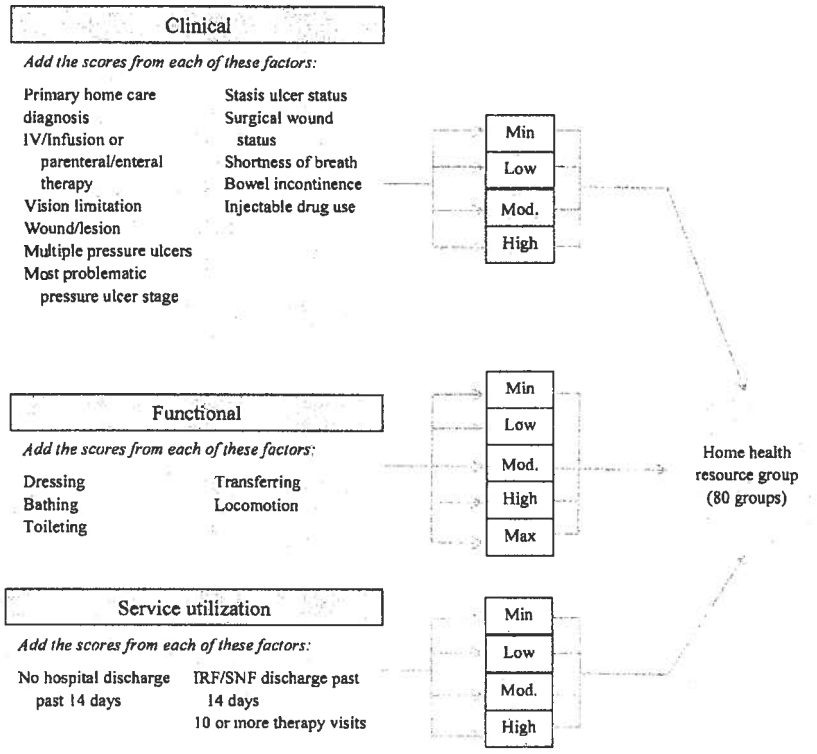
[3] Medicare Program, "Prospective Payment System for Home Health Agencies," *Federal Register* 64:208 (28 October 1999), pp. 58134, 58143.

[4] Office of Inspector General, "Medicare Program; Prospective Payment System for Hospital Outpatient Services, Background," *Federal Register* 65:68 (7 April 2000), pp. 18434, 18442.

[5] MedPAC, "Health Care Services Payment System," Revised October 2008; MedPAC, "Report to the Congress: Issues in a Modernized Medicare Program," June 2005.

Figure 1: Pre-2008 OASIS calculation for HHRG

Clinical, functional, and service information from OASIS determines a patient's home health resource group.



Source: MedPAC, "Report to the Congress: Issues in a Modernized Medicare Program," June 2005

The 10-Visit Threshold

One of the most significant factors outlined in Figure 1 is the inclusion of OASIS "score" metrics that indicate each patient's clinical, functional, and service utilization characteristics. These characteristics are combined to determine each patient's HHRG, which ultimately dictates the reimbursement payment to each home health agency. The payment system through 2007 included a therapy "bonus" when a home health agency provided at least 10 therapy visits. This bonus was substantial, and CMS recognized in its original rulemaking that a 10-visit threshold was "susceptible to manipulation."[6] According to data from CMS, providing 10 visits as opposed to 9 visits increased reimbursement on average 97.5 percent (over $2,000) in 2007.

Figure 2: Average Home Health Episode Payment by Number of Therapy Visits, 2007

Number of Therapy Visits	Payment Amount	Percentage Increase	Number of Therapy Visits	Payment Amount	Percentage Increase
1	$1,600.19		16	$4,431.62	0.43%
2	$1,728.28	8.00%	17	$4,420.06	-0.26%
3	$1,828.10	5.78%	18	$4,475.52	1.25%
4	$1,925.85	5.35%	19	$4,495.57	0.45%
5	$2,124.98	10.34%	20	$4,548.37	1.17%
6	$2,148.46	1.10%	21	$4,514.26	-0.75%
7	$2,162.31	0.64%	22	$4,546.42	0.71%
8	$2,188.76	1.22%	23	$4,540.15	-0.14%
9	$2,198.56	0.45%	24	$4,666.77	2.79%
10	$4,342.66	97.52%	25	$4,572.56	-2.02%
11	$4,390.12	1.09%	26	$4,610.77	0.84%
12	$4,604.31	4.88%	27	$4,642.40	0.69%
13	$4,445.15	-3.46%	28	$4,749.19	2.30%
14	$4,453.79	0.19%	29	$4,796.61	1.00%
15	$4,412.86	-0.92%	30	$4,720.55	-1.59%

Source: CMS

When the PPS system was first implemented, the payment increase threshold was set at 10 therapy visits. CMS implemented the measure in part to discourage "stinting," a term used within the industry to describe agencies rendering the lowest level of service necessary to collect Medicare payment. CMS officials determined 8 hours of combined physical, speech, or occupational ther-

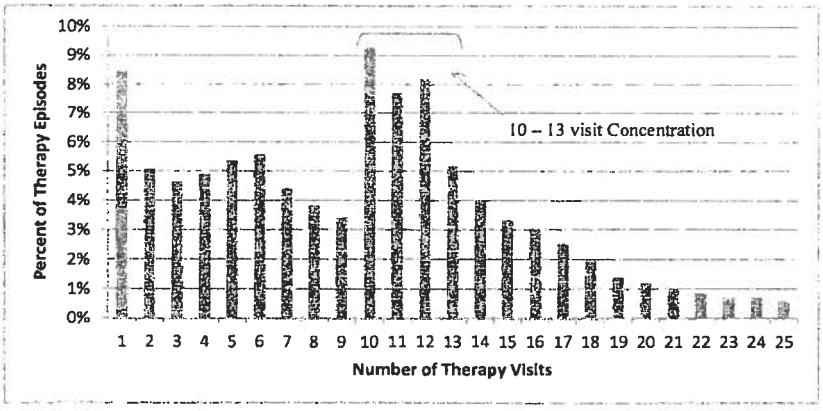
[6] Medicare Program, "Prospective Payment System for Home Health Agencies, Final Rule," *Federal Register* 65:128 (3 July 2000), pp. 41128, 41148.

apy over a 60-day episode would provide a suitable level of care for patients with significant therapy needs; however, a study by Abt Associates commissioned by CMS indicated few patients received that level of care prior to the implementation of PPS. CMS divided the 8 hours into 10 therapy sessions, lasting 48 minutes each, to determine the visit number threshold.[7]

Not surprisingly, the home health episodes that utilized therapy services, also referred to as therapy episodes, demonstrated a concentrated number of visits at or just above thresholds where payments were much greater. The Medicare Payment Advisory Commission (MedPAC) found that episodes with the number of therapy visits between 10 and 13 increased by about 90 percent between 2002 and 2007 at an annual rate of 13.8 percent. However, the percentage of episodes just above and below the 10 to 13 therapy visit range remained relatively unchanged during the same period.[8]

CMS noted similar results, finding the threshold system "might have distorted service delivery patterns."[9] CMS found that the 10- to 13-visit range had the highest concentration of therapy episodes among cases that utilized home therapy. Of all episodes at or above the 10-visit threshold, half were concentrated in the 10 to 13 range.[10]

Figure 3: National Distribution of Episodes with Therapy Visits, 2007



Source: CMS

CMS Attempts Reform: Policy Gamed

In response to the change in home health agencies' practices and evidence of clustering visits just above the 10-visit threshold, CMS proposed significant changes to the therapy reimbursement system

[7] *Id.* 41148.
[8] MedPAC, "Report to Congress," March 2011.
[9] Medicare Program, "Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008, Proposed Rule," *Federal Register* 72:086 (4 May 2007), pp. 25356, 25362.
[10] *Id.*

in 2007, to take effect in 2008.[11] However, CMS retained a tiered therapy threshold system, despite evidence that a threshold system might be gamed or "padded" to increase reimbursement to home health agencies.[12]

Prior to the promulgation of the final rule, CMS considered alternatives to the therapy threshold system. Specifically, the agency evaluated whether using pre-admission status, status of activities of daily living (ADL), specific diagnoses, and additional OASIS variables could enable CMS to determine a patient's need for therapy without a tiered threshold system.[13] CMS ultimately determined none of those variables were sufficient and opted to maintain a threshold system in the final rule with therapy thresholds at 6, 14, and 20 visits. Home health agencies saw a substantially higher payout for those episodes that reach the thresholds within each 60-day period. Smaller graduated steps were also implemented between the thresholds, though they were not as significant as the 6, 14, and 20 visit payment increases.

Figure 4: Average Home Health Episode Payment by Number of Therapy Visits, 2008

Number of Therapy Visits	Payment Amount	Percentage Increase	Number of Therapy Visits	Payment Amount	Percentage Increase
1	$1,544.03		16	$5,010.47	6.48%
2	$1,639.59	6.19%	17	$4,947.58	-1.26%
3	$1,742.85	6.30%	18	$5,275.00	6.62%
4	$1,803.85	3.50%	19	$5,276.52	0.03%
5	$1,925.24	6.73%	20	$6,809.22	29.05%
6	$2,546.26	32.26%	21	$6,834.21	0.37%
7	$3,012.44	18.31%	22	$6,805.92	-0.41%
8	$3,016.42	0.13%	23	$6,841.38	0.52%
9	$3,023.28	0.23%	24	$6,888.63	0.69%
10	$3,532.60	16.85%	25	$6,897.02	0.12%
11	$3,930.55	11.27%	26	$6,909.06	0.17%
12	$4,076.06	3.70%	27	$6,926.91	0.26%
13	$3,954.84	-2.97%	28	$6,994.30	0.97%
14	$4,788.38	21.08%	29	$6,991.55	-0.04%
15	$4,705.76	-1.73%	30	$6,926.49	-0.93%

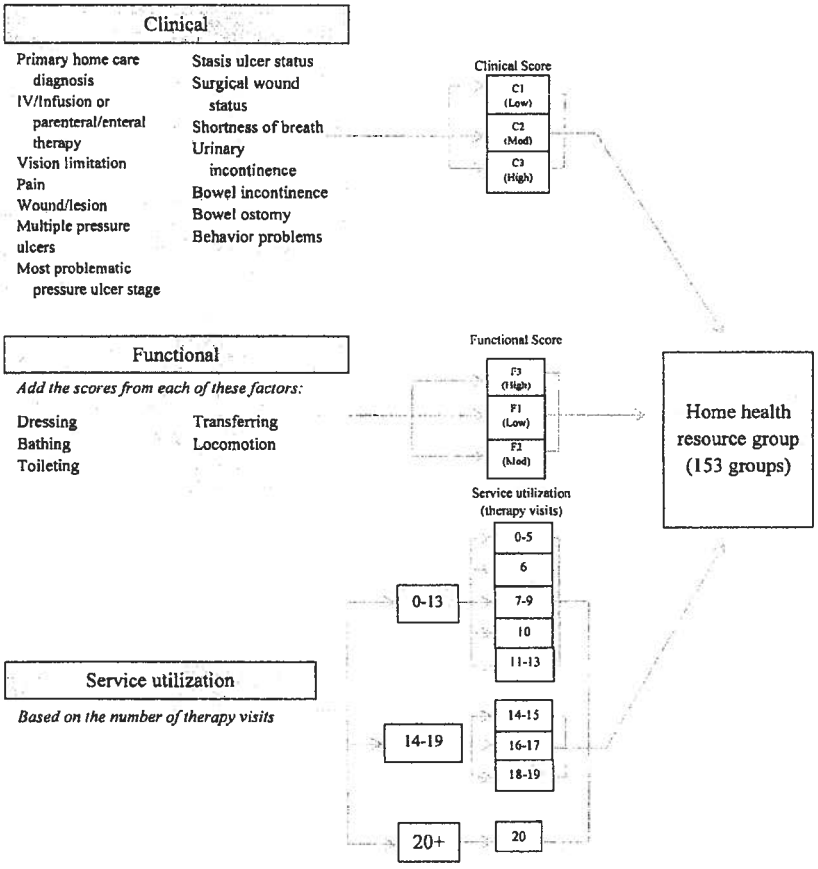
Source: CMS

[11] Medicare Program, "Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008, Final Rule," *Federal Register* 72:167 (29 August 2007), pp. 49762, 49836.
[12] *Id.* 49764.
[13] *Id.* 49835.

CMS also increased the number of payment groups used in determining HHRG from 80 to 153 individual metrics, and provided higher payments for the third and subsequent home health episodes.[14]

Figure 5: 2008 Final Rule OASIS calculation for HHRG

Clinical, functional, and service information from OASIS determines a patient's home health resource group.



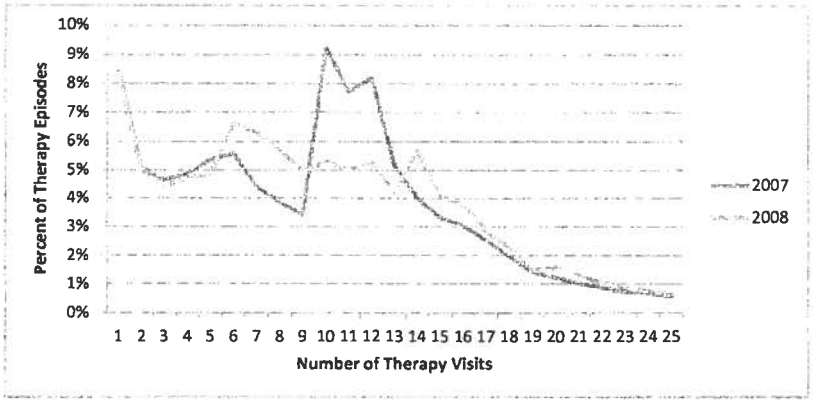
Source: MedPAC, "Health Care Services Payment System," Revised October 2008

Home health agencies rapidly altered their treatment patterns to match the new system, producing what MedPAC called "the swiftest one-year change in therapy utilization since PPS was imple-

[14] *Id.* 49762.

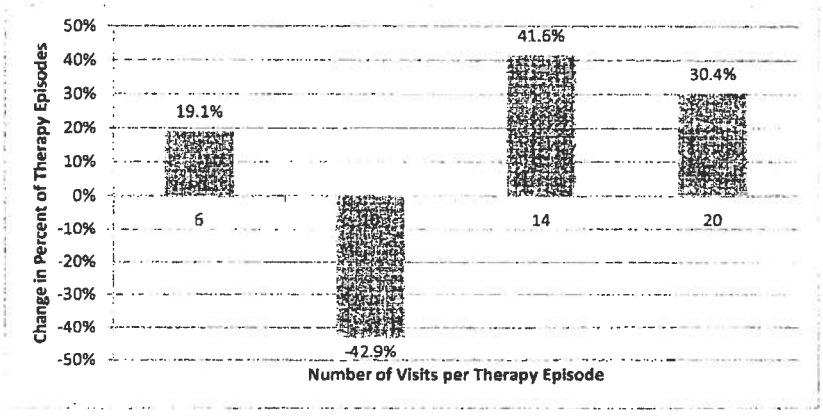
mented."[15] Therapy visits furnished by home health agencies shifted from the original 10-visit threshold to the new 6, 14, and 20 visits. According to MedPAC, "payment for episodes with 6 to 9 visits increased by 30 percent, and the share of these episodes increased from 8.6 percent to 11.6 percent. Payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 14.5 percent." In addition, the number of episodes at the 10 to 13 therapy visit range dropped approximately 28 percent.[16]

Figure 6: National Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: CMS

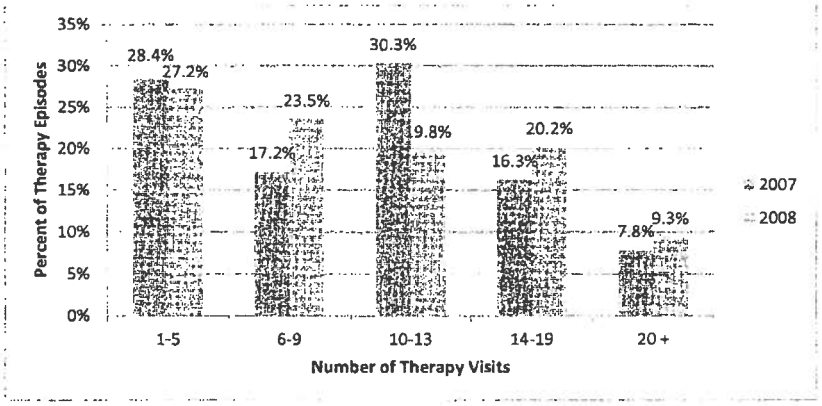
Figure 7: National Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: CMS

[15] MedPAC, "Report to Congress," March 2011, p. 183.
[16] *Id.*

Figure 8: National Distribution of Episodes with Therapy Visits, 2007 vs. 2008



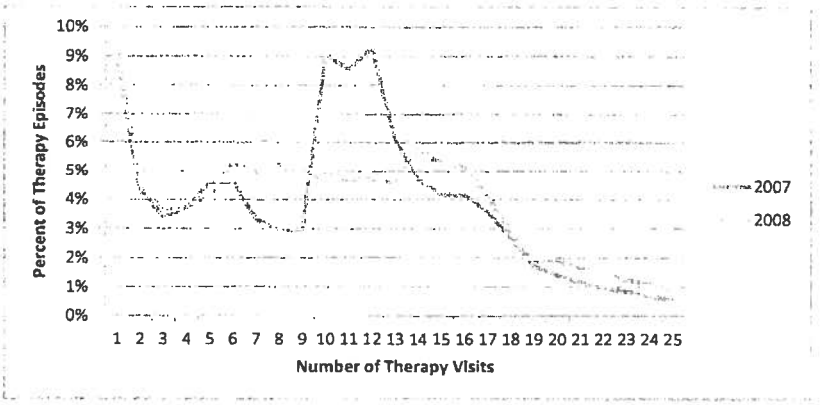
Source: CMS

Amedisys

A review of internal documents and communications provided to the Committee by Amedisys shows that Amedisys management directed employees to adjust the number of home health therapy visits to maximize Medicare payout to the company after the 2008 changes to the Medicare payment system.

In addition, the Committee's review substantiates concerns raised by the Medicare Payment Advisory Commission that the "incentives of the therapy thresholds encourage providers to consider payment incentives, and not necessarily patient characteristics, when determining what services to provide."[17]

Figure 9: Amedisys Distribution of Episodes with Therapy Visits, 2007 vs. 2008



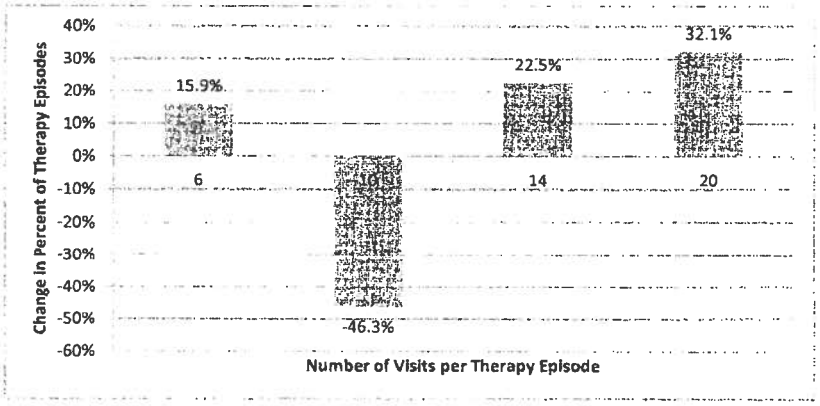
Source: Amedisys

[17] MedPAC, "Report to Congress," March 2011, p. 183.

Therapy Metrics

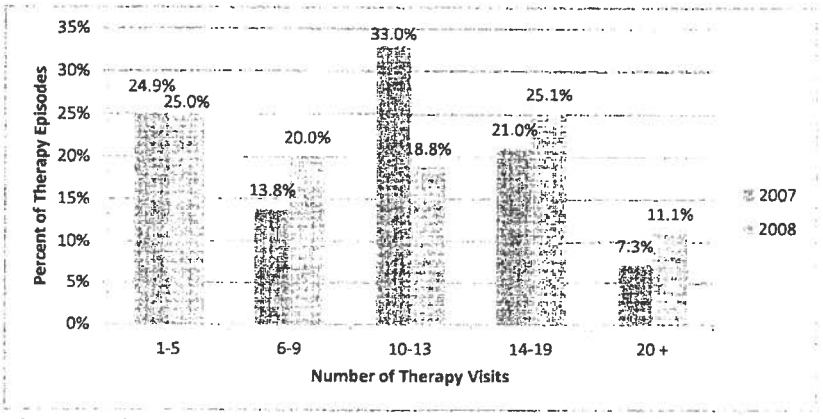
As Figure 9 indicates, in 2007, 9.1 percent of Amedisys's therapy episodes received 10 visits while 2.9 percent of the therapy episodes received 9 visits. In 2008, after the CMS PPS therapy changes, the number of therapy episodes that received 10 visits dropped to 4.9 percent. Also from 2007 to 2008, the number of therapy episodes receiving 6 visits increased from 4.6 percent to 5.3 percent, and the number of therapy episodes receiving 14 visits increased from 4.7 percent to 5.8 percent.[18]

Figure 10: Amedisys Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Amedisys

Figure 11: Amedisys Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Amedisys

[18] Amedisys Therapy Episode Distribution, AMEDSFC00000001—AMEDSFC00000002.

Home health episodes with therapy reimbursements accounted for 71 percent of Amedisys's Medicare revenue in 2009 at $878,535,009. Amedisys's total Medicare revenue for 2009 was $1,229,755,214.[19] Medicare reimbursements consisted of 88 percent of Amedisys's revenue in 2009.[20]

The 10-Visit Therapy Threshold Prior to 2008

The large disparity between the percentage of Amedisys therapy episodes receiving 9 and 10 visits prior to the 2008 CMS PPS payment changes is not surprising given the employee training materials in circulation at the time. A 2006 PowerPoint presentation encouraged Amedisys managers to generate a report to help "the [Directors of Office Operations (DOOs)] focus on therapy utilization." The presentation instructed Amedisys DOOs to "Look for patients that have 7, 8, 9 visits and try to get the 10 visits to make therapy threshold."[21]

The same presentation also encouraged DOOs to use an Adjusted Revenue Report "to identify patients that have had or will have revenue adjustments made to the expected payment amount. . . . This report gives you the best opportunity to convert or prevent [Low Utilization Payment Adjustments (LUPA) patients] and non therapy threshold patients."[22]

LUPAs are patients "with four or fewer home health visits" and "are reimbursed under the Low Utilization Payment Adjustment (LUPA) on a per-visit basis and payment varies depending on the type of health care professional making the visit."[23] Generally, home health agencies see LUPA cases as less profitable than mid- or high-therapy utilization cases.

Another educational document stated that when patients are "close to the 10-visit threshold," therapists should ask, "What is the patient's rehab potential. . . . Does that patient have any balance issues that might create a high risk for falls. . . . Is the patient appropriate for other therapy services or disciplines?"[24]

Amedisys Management's Response to the 2008 CMS Payment Changes

Amedisys's corporate management saw the proposed 2008 CMS PPS changes as an opportunity to increase its reimbursements from Medicare by altering internal clinical and marketing practices. A document outlining Amedisys CEO Bill Borne's strategic plan stated that the proposed changes in the 2008 home health PPS system "provides an opportunity for Amedisys to refine internal practices in order to enhance shareholder value despite the payment changes."[25]

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[19] Amedisys Medicare Reimbursement, AMEDSFC00000003.

[20] Amedisys 2010 Annual Report, p. 14, *http://www.amedisys.com/pdf/Amedisys_annualrep10.pdf.*

[21] Amedsys PowerPoint, Help with Reports, 2006, AMEDSFC00001477—AMEDSFC00001543, *AMEDSFC00001484.

[22] *Id.*

[23] Home Health Study Report prepared for CMS by L&M Policy Research, January 11, 2011, p. 6.

[24] Amedisys PowerPoint, Home Health Care Team Conference Overview, 2006, AMEDSFC00001544—AMEDSFC00001593, *AMEDSFC00001583.

[25] Amedisys Board Meeting Minutes, October 27, 2007, AMEDSFC00000812—AMEDSFC00000845, *AMEDSFC00000820.

According to the minutes of an Amedisys board meeting held at the Las Ventanas Hotel in Los Cabos, Mexico on July 24, 2007, Chief Information Officer Alice Ann Schwartz reported, "the Company had formed a committee called the 'A-Team' whose specific purpose was to develop strategic clinical programs and cost-cutting/efficiency measures to address the proposed case mix refinements."[26]

Creating Therapy-Based Programs to Boost Revenue

A list of talking points used during a June 13, 2007 conference call regarding the proposed PPS changes contained a strategy for "Clinical Development," which included "Data Mining of most profitable/least profitable diagnoses and the financial impact. . . . Develop an infrastructure to track monthly percentage growth in desirable cases. . . . Recommendations of new programs with conceptual framework submitted based on analysis/data mining."[27]

During this conference call, a document was distributed titled "Data Mining Strategies Handout" which ranked medical diagnoses by average profit per episode. The document laid out a comprehensive strategy to increase therapy visits for certain therapy episodes that were beneath key thresholds, adding therapy visits into non-therapy episodes, and substituting physical therapy for skilled nursing visits. The document stated that a therapy based wound care program in which "[physical therapy] replaces [skilled nursing] visits in wound care episodes w/o therapy" would bring an "Added Revenue" of "$1,400,000."[28]

Additionally, an August 2007 training document stated, "If we added only 6 Therapy visits to 3% of [congestive heart failure] patients who are F2F3 but received no therapy—8809 episodes, net to company almost half a million. Imagine what the revenue for the agencies will be!"[29]

In addition to discussing clinical development strategies based on the most profitable and least profitable diagnoses, the team also discussed "Developing a strategic sales focus upon preferred patient mix."[30]

Notes from a conference call on August 2, 2007 led by Amedisys Chief Operating Officer Larry Graham stated that a "Key Operational Initiative" of Amedisys's "Case Mix Refinement Strategy" was "Growth of Focused [Disease Management] Programs in 2008" and a "New Therapy Clinical Tracks rollout" on September 15, 2007.[31]

A PowerPoint presentation introducing Amedisys's "therapy wound care initiative," which added physical therapy visits to home health episodes, noted that treating a wound care patient with 14

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[26] Amedisys Board Meeting Minutes, October 27, 2007, AMEDSFC00000812—AMEDSFC00000845, *AMEDSFC00000816.

[27] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093067.

[28] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093065.

[29] Therapy and Specialty Program Initiatives, VP/RA/RDBD Education, August 15, 2007, AMEDSFC00076748—AMEDSFC00076775, *AMEDSFC00076766.

[30] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093068.

[31] Conference Call with Larry Graham, August 2, 2007, Case Mix Strategy Handouts, AMEDSFC00064385—AMEDSFC00064395, *AMEDSFC00064394.

and 20 physical therapy visits would more than double the company's Medicare reimbursement for the episode in two examples. One example explained that the 2008 Medicare reimbursement without therapy services would be $2,908.13, as opposed to $6,011.67 with 14 physical therapy visits under the new system.[32]

According to an Excel spreadsheet used to track tasks of the "A-Team" committee, Amedisys management decided, as part of its clinical strategy, to incorporate "therapy into [the congestive heart failure] program" and institute "Aggressive [Balanced For Life] and multi-disciplinary therapy program launches in 2008."[33]

A 2007 document titled "Therapy Initiatives Update" was distributed during an August 31, 2007 "A-Team" conference call. The document indicates that the average HHRG for Balanced for Life reimbursement was $4,100 in 2007. In 2008, the document noted a projected HHRG reimbursement increase to $4,700 because occupational therapy was added to the Balanced for Life program.[34]

Altering Patient Care Guidelines to Hit Therapy Thresholds

Amedisys altered its clinical recommendations for the number of therapy visits, known as "clinical tracks," as a result of the CMS payment changes in 2008. The new clinical tracks correspond to the new payment thresholds.

Prior to the CMS payment changes, the "Better Balance At Home" and "Better Strength At Home" programs had a recommended 3 to 12 therapy visits.[35] An internal Amedisys PowerPoint presentation stated that "New case mix weight adjustments proposed by medicare provided a great opportunity to make some company wide changes in the rehab clinical tracks" and the new "Rehabilitation @ Home" program "Replaces Better Strength and Better Balance."[36] However, the new clinical recommendations changed after CMS implemented its payment changes. Instead of the number of visits being in the 3 to 12 range, the new visit range for "Rehabilitation @ Home" became 8, 16, or 22 visits. All 3 of these visit tracks were 2 visits above each therapy payment threshold.[37]

Amedisys Staff was Pressured to Adhere to New Patient Care Guidelines

While the training material regarding clinical track changes in 2008 stated "visit numbers are guidelines" and "Care plans are made patient specific and appropriate to the needs of that patient," e-mails and documents provide evidence that Amedisys executives pressured employees to reach specific therapy payment thresholds.

An Amedisys PowerPoint authored by Amedisys Vice President of Disease Management Anne Frechette describes "Key Operational

[32] Amedisys PowerPoint presentation, Therapy Wound Care, September 26, 2007, AMEDSFC00070246—AMEDSFC00070276, *AMEDSFC00070273.
[33] A-Team Case Mix Committee Action Items, December 2007, AMEDSFC00070083—AMEDSFC00070103, *AMEDSFC00070085.
[34] "Therapy Initiatives Update," August 30, 2007, AMEDSFC00076174—AMEDSFC00076177, *AMEDSFC00076177.
[35] Amedisys Rehab Clinical Track Options, AMEDSFC00001347—AMEDSFC00001350, *AMEDSFC00001347.
[36] "Amedisys Rehabilitation 2007–2008, AMEDSFC00001846—AMEDSFC00001862, *AMEDSFC00001848.
[37] Clinical Track Guidelines—Revised, AMEDSFC00001935.

Initiatives" for 2008 including an initiative to "Improve compliance with scheduling according to clinical tracks" by transferring that responsibility from the agency clinical manager to a [Quality Care Coordinator].[38] The Quality Care Coordinator's job is to oversee clinical decisions and documentation at Amedisys agencies.[39]

On February 25, 2008, Amedisys Vice President of Quality Management and Analytics Tasha Mears distributed an e-mail with the subject line, "Therapy Management in 2008." The e-mail reminded Amedisys management of the "company wide differences in reimbursement in 2008 versus 2007 based on the total therapy visits per episode." The e-mail also included a chart showing "changes in revenue per episode, moving from 'bucket' to 'bucket' in 2008." Lastly, the e-mail included a report ranking "individual agencies, AVP's and VP's by 14+ total therapy visits per episode, and shows how many episodes are in each therapy 'bucket'."[40]

The following day, Amedisys Area Vice President of Operations in North Alabama Teresa B. Mills wrote in an e-mail urging conformance with the new clinical tracks:

> It is imperative that we are compliant with the clinical tracks for Rehab that were made available to your agency December 2007. After reviewing each of the agencies Episode Statistics for Feb.1 thru today it is evident that we as a region are not following the established guidelines for clinical management of therapy utilization. 65 percent or greater of your episodes that have ended this month fell under the 2008 PPS rules and discovery is that most of your episodes have fallen into the Grouping Step 1 or Grouping Step 3 with 0–13 therapy visits. The Rehab Clinical Traction Options selection sheet is based on the therapist's assessment of the geriatric rehab patient with attention to the clinical and functional scoring established on the evaluation. There are only 3 of the 14 Therapy Tracks that have less than 14 visits to be scheduled—they are Rehab at Home–DO1 for CIF1–8 visits recommended, Dysphagia at Home–001 for C2–3 F2–3 for 8 SLP visits, and Orthopedics I–001 for C1–2 F1 for 8 PT visits. Most patients in this clinical and functional status would not be a patient in home health for any length of time. Most of your patients fall into a C2F2–3 status or greater and would more appropriately be placed on the other tracks having 14–22 visit options and are based on Clinical 2–3 and Functional 2–3 scoring on the OASIS. This is your guideline and the Clinical Managers are to work with the therapists to obtain the accurate track selection—do not use any of the old therapy tracks.[41]

A February 27, 2008 e-mail from the Amedisys Vice President of Florida Operations Dan Cundiff to Amedisys managers in Florida stated:

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[38] Amedisys Powerpoint presentation, Key Operation Initiatives—2008, VP of Disease Management, Anne Frechette, AMEDSFC00066778—AMEDSFC00066899, *AMEDSFC00066798.

[39] "Remote Quality Care Coordinators," AMEDSFC00064470—AMEDSFC00064499, *AMEDSFC00064482.

[40] E-mail from Amedisys Vice President of Quality Management and Analytics, Tasha Mears, February 25, 2008 and attachments, AMEDSFC00072633—AMEDSFC00072642; AMEDSFC00072702—AMEDSFC00072709; AMEDSFC00072769, *AMEDSFC00072634.

[41] E-mail from Amedisys Area Vice President Teresa Mills, February 26, 2008, AMEDSFC00092129.

> We need to work immediately to adjust our '10 therapy threshold' mindset. See the email from Tasha yesterday. At 10, our episode value drops by over 880.00 14–15 is where we need to be . . . and yes, I understand that our visits per episode will go up . . . but I would rather be profitable than have a low visits/episode. At 7–9 we have upside, but the overall episode value is less than I would like to see for cases involving therapies. If we continue to drive meeting 10 therapies . . . we will be cooked. 11–13 as well.[42]

Another e-mail by Mr. Cundiff to Amedisys managers in Florida on February 29, 2008 stated:

> We still drove to a 10 therapy threshold . . . and thus, our values per episode were HAMMERED. We must stop thinking that 10 therapies maximizes our reimbursement.
>
> The new upper level threshold is now 14 therapy visits. **When clinically appropriate**, lets drive to that number. From 10–13 visits, we become significantly less profitable . . . to the tune of an 800.00+ negative adjustment from 2007 rates. [emphasis in original]
>
> Falling in the 10–13 range without a solid set of reasons is real shame, and the only acceptable reason is that it was absolutely the best thing for the patient. [sic] I will never . . . NEVER argue that point, but I would also suggest, that in most cases, patients benefit from additional therapy beyond 10–13 visits.
>
> Let's get with the newer reimbursement schedule . . . improve our outcomes by more therapy patient contact . . . and win all around. Lastly, let's not be overly concerned about visits per episode . . . until we maximize our revenue opportunities . . . when supported by clinical standards.[43]

Internal reports about Amedisys branches in Missouri also cited the need for clinical tracks to be followed. One report stated that the "Rev/Episode is low due to the under utilization of therapy" and recommended that in order to "Increase Revenue per episode via episode management from $1619 to $2500" that the area vice president of operations should "Work with DOO to insure [sic] usage of clinical tracks."[44]

Gentiva

Therapy Metrics

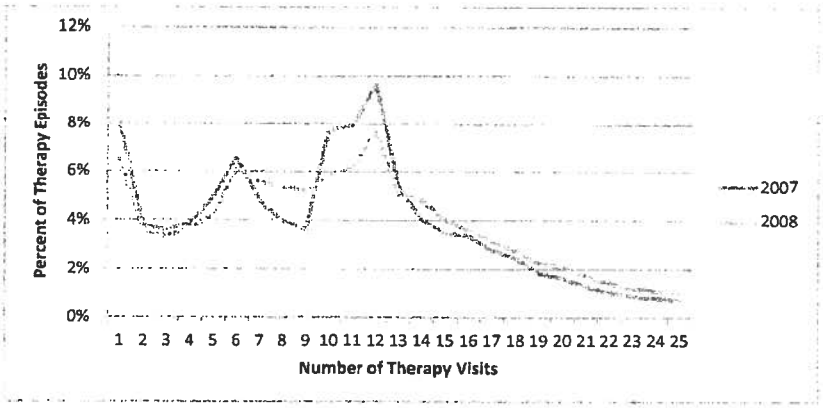
As Figure 12 indicates, in 2007, 7.7 percent of Gentiva's therapy episodes received 10 visits while 3.6 percent of the therapy episodes received 9 visits. In 2008, the number of therapy episodes that received 10 visits dropped to 5.8 percent.[45]

Also from 2007 to 2008, the number of therapy episodes receiving 6 visits dropped from 6.5 percent to 6.1 percent. However, the per-

[42] E-mail from Amedisys Vice President for Florida Operations Dan Cundiff, "January," February 27, 2008, AMEDSFC00092016.
[43] E-mail from Amedisys Vice President for Florida Operations Dan Cundiff, "episode follow up," February 29, 2008, AMEDSFC00092017.
[44] E-mail from Mike Hamilton to Jill Cannon and William Mayes, March 10, 2008 and attachments. AMEDSFC00093359—AMEDSFC00093371, *AMEDSFC00093360.
[45] Gentiva Therapy Episode Distribution, GEN 000015.

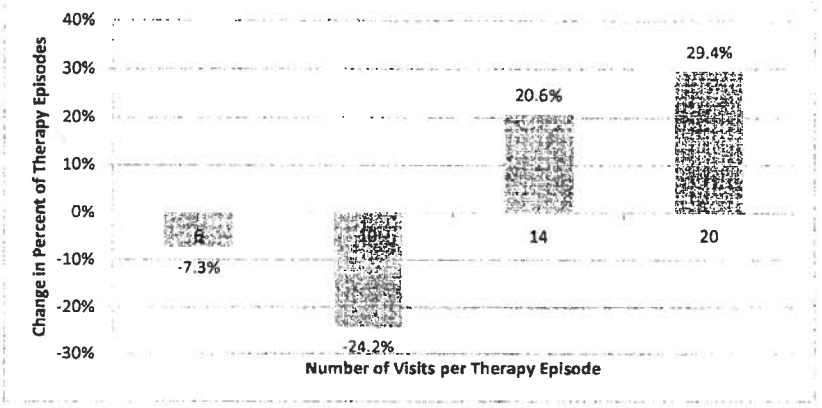
centage of therapy utilization in the 6-visit through 9-visit range increased, from 18.9 percent in 2007 to 22.1 percent in 2008. The number of therapy episodes receiving 14 visits increased from 4.0 percent to 4.8 percent. And the number of therapy episodes receiving 20 visits increased from 1.6 percent to 2.1 percent.[46]

Figure 12: Gentiva Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Gentiva

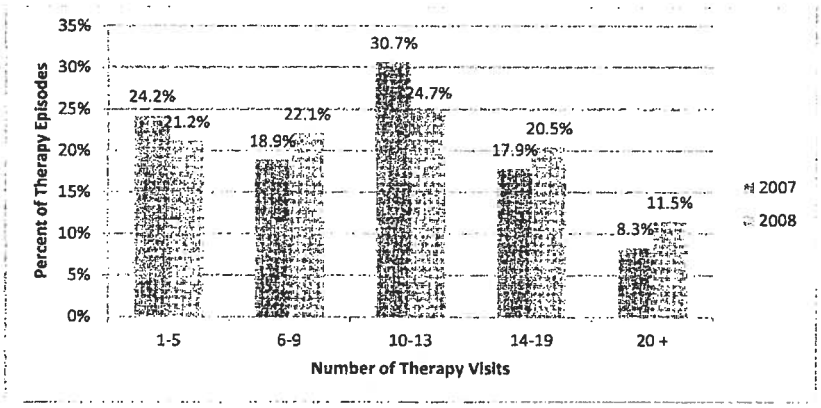
Figure 13: Gentiva Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Gentiva

[46] *Id.*

Figure 14: Gentiva Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Gentiva

Home health episodes with therapy reimbursements accounted for 78 percent of Gentiva's Medicare revenue in 2009 at $606,921,660. Gentiva's total Medicare revenue for 2009 was $773,673,026.[47] Medicare reimbursements consisted of 82 percent of Gentiva's revenue in 2009.[48]

Gentiva Management Response to the 2008 CMS Payment Changes

Internal documents and e-mails show that Gentiva's management discussed increasing therapy visits and expanding specialty programs to increase Medicare reimbursements as a result of the proposed 2008 CMS payment changes.

Vice President and Chief Clinical Executive Susan Sender wrote in a January 5, 2007 e-mail regarding the CMS payment changes that there was "an internal group . . . crunching utilization and outcomes data to determine whether revisions to our therapy protocols are clinically defensible."[49]

According to a Gentiva Excel spreadsheet analyzing the proposed 2008 CMS payment changes, the company would earn an additional $11 million from Medicare if "[t]herapy visits provided increased 2 to 4 visits to reach 6 and 14 visit plateaus."[50]

Gentiva Competitive Ranking System

Gentiva developed a competitive ranking system for their management that served to drive therapy visit patterns toward the more profitable thresholds. Through the ranking system, known internally as the Key Indicator Report (KIR), Gentiva administrators assigned team names to each region of operation, such as the Mid-

[47] Gentiva Medicare Reimbursement, GEN 000017.
[48] Gentiva 2010 Annual Report, page 18, *http://files.shareholder.com/downloads/GTIV/1328045690x0x456437/CEA1782E-FB2C-4850-A530-9CF06AA6C55B/Gentiva_AR_2010.pdf.*
[49] E-mail from Vice President and Chief Clinical Executive Susan Sender, RE: PPS Refinements Proposed Regulations, E–GEN 079938.
[50] Changes in Profitability due to Proposed Changes in Therapy Reimbursement, GEN 013823.

Atlantic "Spider Monkeys" and the Carolina "Killer Bees."[51] Teams were then ranked based on a list of 21 individual, weighted metrics primarily designed to maximize profits.[52]

A February 16, 2009 e-mail noted that the company planned to eliminate one metric, visits per episode over the last 4 months, from the ranking system because it "runs counter to our initiative to increase [physical therapy.]"[53] The company later indicated that this metric was not eliminated from the KIR reports.[54]

The highest-ranking teams received encouraging company-wide e-mails such as "The Killer Bees . . . have a taste for victory, served best with a side of Spider Monkey . . ." and "The race is getting closer for #1 . . . I keep hearing the south will rise again?"[55] First place teams also received a monetary bonus during an annual company meeting.[56] In 2007, KIR bonuses totaled $161,811.[57]

In January 2010, Gentiva administrators added two new KIR metrics that would increase a region's rank based on the percentage of therapy visits that fell in the most profitable therapy visit range, between 7 and 20 sessions.[58]

There is also evidence of a direct push toward therapy thresholds in Gentiva's internal educational materials. A presentation titled "PPS Refinements" noted "About 12% of Gentiva's episodes have LUPA adjustments, less than five visits in the episode." The document stated that it is "Interesting how many are at 5, could we have done one more visit??"[59]

An internal analysis presented to CEO Tony Strange in a September 7, 2007 e-mail found that "increasing therapy visits by an average of 2 visits per episode will increase revenue by approximately $350 to $550 per episode. Adding therapy services (6 visits) to patients with high functional needs will increase revenue by about $700 per episode."[60]

An October 2007 presentation showed that a Gentiva employee was tasked to "Build the case to substantiate increased therapy, including PT, OT, and ST."[61]

In a September 29, 2008 e-mail, Area Vice President for Financial Operations Pete Cavanaugh wrote, "I'd like to know what overall impact we'll get if we push for an increase in therapy."[62]

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[51] E-mail from Vice President of Finance, Investor Relations Brandon Ballew, "KIR Regional Rankings though October 2009," December 11, 2009, E–GEN 024576—E–GEN 024600, *E–GEN 024578.

[52] Response to June 17 2011 SFC Set of Supplemental Questions, June 24, 2011, GEN 000003—GEN 000004, *GEN 000003.

[53] E-mail from Area Vice President Pete Cavanaugh, "AVP Rankings," February 16, 2009, E–GEN 042577.

[54] E-mail, "Regional Ranking April 2010," June 2, 2010, E–GEN 024576—E–GEN 024600, *E–GEN 024577.

[55] E-mail, "AVP Rankings through April 2009," May 27, 2009, E–GEN 024576—E–GEN 024600; e-mail, "Regional Ranking April 2010," June 2, 2010 E–GEN 024576.

[56] Gentiva Response, June 16, 2011, GEN 000001—GEN 000002, *GEN 000002.

[57] Response to June 17 2011 SFC Set of Supplemental Questions, June 24, 2011, GEN 000003—GEN 000004, *GEN 000004.

[58] *Id.*

[59] Gentiva PowerPoint, "PPS Refinements," GEN 013811—GEN 013820, *GEN 013814.

[60] E-mail from Perri Southerland to CEO Tony Strange, PPS Refinements, Therapy Analysis, September 7, 2007, E–GEN 025083.

[61] Gentiva PowerPoint, "Gentiva Rehab," October 2007, GEN 013799—GEN 013810, *GEN 013808.

[62] E-mail, "PPS Therapy Impact Analysis," September 29, 2008, E–GEN 024516—E–GEN 024517, *E–GEN 024517.

In the same e-mail string, Area Vice President of Finance John N. Norlander wrote "Andrew can work with the PPS Files to see if we move 1% of <7 visits and see the last 6 months impact by Region—Net Revenue, Gross Margin and EBITDA."[63]

Senior Vice President and Chief Clinical Officer Dr. Charlotte Weaver wrote in a January 7, 2009 e-mail that "operations did a . . . management assignment" which "addressed getting more therapy visits in an episode of care."[64]

In a May 3, 2010 letter to CEO Tony Strange, one departing physical therapist expressed disappointment with the direction of Gentiva. "I see the push to treat by metrics not by what the patients need," the employee wrote. "Treating by numbers is . . . making the clinicians feel their professional judgment is being questioned. Again, not sitting on plateaus is understandable but pushing to thresholds based on what their diagnosis is, not by what the patient needs is just wrong."[65]

In addition to discussions about increasing the number of therapy visits performed to increase revenue, Gentiva management discussed expanding therapy intensive specialty programs. An Excel spreadsheet listed "Specialty Programs (Orthopedics) increasing visits" as a means to increase revenue in the face of the 2008 CMS changes.[66]

CEO Tony Strange wrote in a July 29, 2008 e-mail that, "Amedisys is on our heals [sic] related to growth in Specialties. I want to see us kick it up a notch related to launches. Especially, in the programs that drive high % Medicare growth."[67]

LHC Group

LHC Group Therapy Metrics

Therapy metrics provided to the Committee by LHC Group point to a pattern of attempting to achieve the most profitable number of therapy visits. As Figure 15 indicates, in 2007, 20 percent of LHC Group's therapy episodes received ten visits while only 2.6 percent of the therapy episodes received nine visits. In 2008, the number of therapy episodes that received ten visits dramatically dropped to 6.9 percent. Also, from 2007 to 2008 the number of therapy episodes receiving six visits increased from 2.5 percent to 5.5 percent. The number of therapy episodes receiving 14 visits increased from 4.6 percent to 8 percent. And the number of therapy visits receiving 20 visits increased from 0.7 percent to 2.1 percent.[68]

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[63] *Id.* *E–GEN 024516.

[64] E-mail from Senior Vice President and Chief Clinical Officer Charlotte Weaver, January 7, 2009, E–GEN 028021—E–GEN 028022.

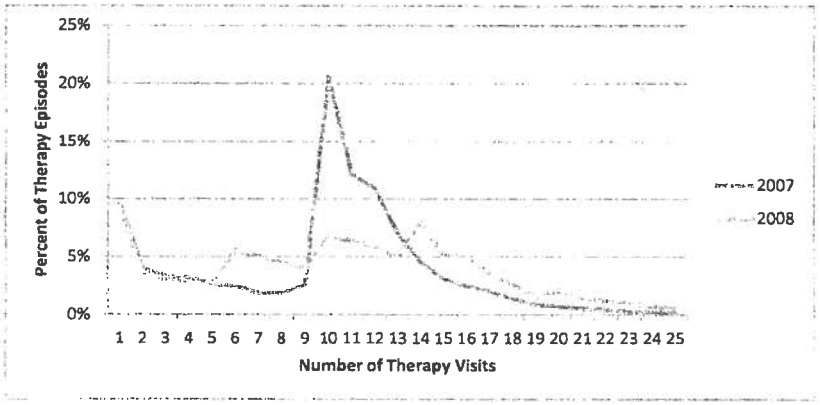
[65] E-mail to CEO Tony Strange, "Parting Comments," May 3, 2010, E–GEN 034749.

[66] Gentiva data analysis, GEN 014163—GEN 014175.

[67] E-mail from CEO Tony Strange, "RE: Specialties growth," July 29, 2008, E–GEN 037384—E–GEN 037384, *E–GEN 037384.

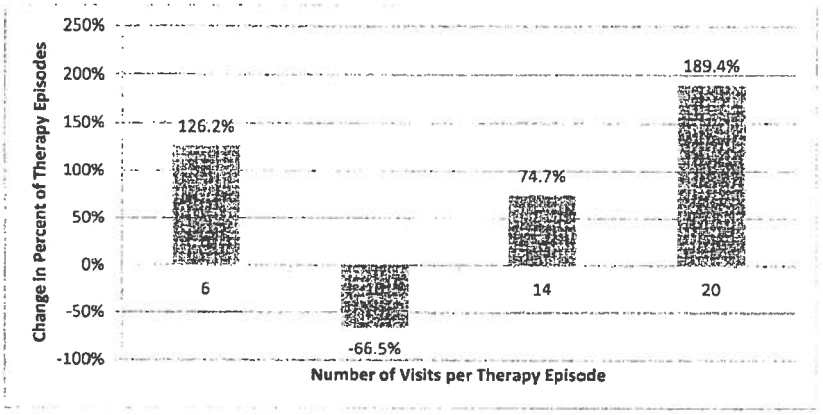
[68] LHC Group Therapy Episode Distribution, LHCGROUP_00000001.

Figure 15: LHC Group Distribution of Episodes with Therapy Visits, 2007 vs. 2008



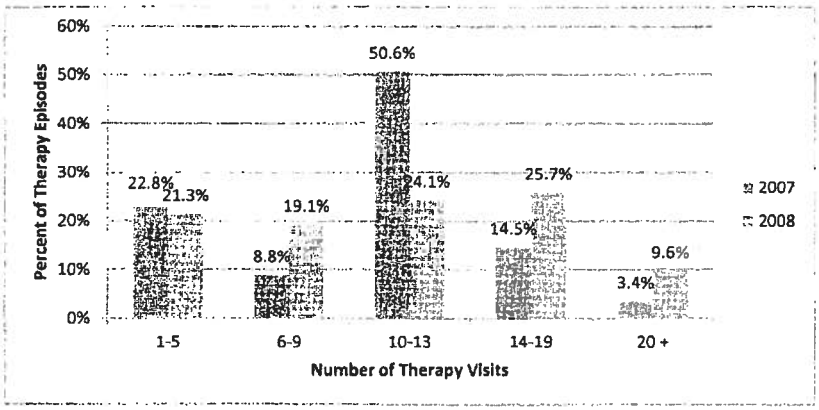
Source: LHC Group

Figure 16: LHC Group Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: LHC Group

Figure 17: LHC Group Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: LHC Group

Home health episodes with therapy reimbursements accounted for 50 percent of LHC Group's Medicare revenue in 2009 at $184,571,930. LHC Groups's total Medicare revenue for 2009 was $366,673,596.[69] Medicare reimbursements consisted of 81.7 percent of LHC Group's revenue in 2009.[70]

LHC and the 10-Visit Threshold Prior to 2008

A January 30, 2008 e-mail written by the Vice President of Quality and Performance Improvement, Barbara Goodman indicates that the primary consideration for determining the number of visits in LHC Group's therapy programs was financial. She wrote, "Most of our programs (low vision, Pelvic Floor) called for ten visit [sic] because it was at that threshold that we actually made additional revenue for therapy."[71]

Additionally, there is evidence that therapists were pressured to hit the 10-visit threshold even when 10 visits may not have been medically necessary. A June 5, 2007 e-mail from Mississippi Regional Manager Cindy Keeton shows administrators considered calling on physical therapist Rocky Goodwin to counsel a fellow therapist who refused to trend toward the 10-visit threshold:

> "It has been a constant battle with her regarding the 10 visit threshold. She even bucks when a MD orders a specific frequency and if she feels they do not need it then she refuses. . . . You can see that I have an unusual situation in getting this employee educated on home health therapy as related to hospital. It was suggested that you might have a therapist that

[69] LHC Group Medicare Reimbursement, LHCGROUP_000000003, LHCGROUP_000000004.
[70] LHC Group 2010 Annual Report, p. 13, *http://files.shareholder.com/downloads/LHCG/1328064157x0x466257/715C478B-B77C-4F20-9EC2-346E81F15C23/LHC_AR_Final.pdf.*
[71] E-mail from LHC Group's Barbara Goodman, January 30, 2008, LHCGROUP_00007923—LHCGROUP 00007928, *LHCGROUP_00007923.

> would be willing to come here and work with her. I think the name Rocky was mentioned."[72]

A July 8, 2007 e-mail shows that LHC Group physical therapist Rocky Goodwin wrote, after meeting with another physical therapist on a separate occasion, that he tried to convey "several pointers as to how to 'finish out' a therapy episode where only 6–9 visits are on the book and he needs something else to do to get to 10 visits. There are several old tricks up my sleeve that I told him about from a clinical standpoint that he should feel better about using to get to the 10 visits."[73] Another e-mail, dated October 1, 2007 describes Rocky Goodwin as a "PT . . . who assists the start up team occasionally in an education role in our region." In the e-mail, Area Manager Liz Regard recommended Goodwin as a resource to help train staff on the new therapy visit threshold rates based on the 2008 CMS changes.[74] The same e-mail went on to request "information that would tell us the types of patients that Medicare would see justification for 6 therapy visits, 14 therapy visits, etc."[75]

LHC Group Response to 2008 CMS Payment Changes

In a September 21, 2007 e-mail following the announcement that CMS was changing its therapy payment structure, LHC Group Division Vice President Liz Starr proposed the "Development of new therapy programs that will now be VERY financially sound but would not have been in the past PPS reimbursement program."[76]

In an April 4, 2008 e-mail to an Arkansas area sales manager written after CMS altered the therapy payment thresholds, LHC Group CEO Keith Myers wrote about the need to increase the number of therapy visits performed by LHC Group in order to increase case mix and revenue:

> It's all in the therapy Kevin. Episodes in the 0–5 therapy buckets have been hit the worst. We have over 70% of episodes in the 0–5 bucket since January 1, 2008. We are looking at freestanding agencies in business development that are doing much better than we are with regard to 2008 case mix and most of them actually have a pick up under the new rule. The key is that they have less than 50% of their episodes in the 0–5 therapy buckets. We took a financial hit for any therapy provide [sic] below 10 visits in the past, but under the new system an episode with 6 therapy visits is better than episode [sic] with 0–5 therapy visits. The new "10 visit threshold" is actually 6 visits on the low side and 20 visits on the high side. In other words, once you get to 6 visits, the more therapy visits provided the better, up to 20 visits. We need to move episodes out of the 0–5 buckets and up to the 6 and 7–9 buckets on the

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[72] E-mail from LHC Group Area Manager to Rocky Goodwin/LAHCG, June 13, 2007, LHCGROUP__00046851—LHCGROUP 00046852, *LHCGROUP__00046851.

[73] LHC Group physical therapist Rocky Goodwin, July 8, 2007, LHC—00046855—LHCGROUP 00046856, *LHC—00046855.

[74] E-mail from LHC Group Area Manager to Jessica VanBuskirk, October 1, 2007, LHCGROUP__00053367.

[75] *Id.*

[76] E-mail from LHC Group Division Vice President Liz Starr to Senior Vice President of Operations Don Stelly, September 22, 2007, LHCGROUP__00020460—LHCGROUP 00020463, *LHCGROUP__00020460.

> low end, and look for higher therapy need cases on the high end.
>
> I think our sales people should be working closely with operations to recruit and employee [sic] more PT's, PTA's, OT's and COTA's. Sales incentives are driven by admission × case mix, and the only way to get case mix up is to increase therapy utilization. We need to look for opportunities especially within the OT area, i.e. low vision, etc.[77]

Similar instructions were issued by LHC Group Division Vice President of Home Based Operations, Angie Begnaud, who wrote in a January 18, 2008 e-mail, "We want to do more therapy visits. The point was made by Johnny that we still see our agencies doing only 10–12 visits, when in fact some of these patients we could be doing 14–20 visits if needed."[78]

The instructions from LHC Group management to alter therapy practices in the face of the 2008 PPS changes stood in contrast to advice offered in an internal company presentation that read, "Be cautious of any deliberate plan to alter therapy practice patterns in response to a threshold change. Shifts in practice in order to maximize revenue may draw unwanted attention from Medicare and are NOT recommended."[79]

LHC Employees Pressured to Boost Therapy

Despite LHC Group's claim in its June 4, 2010 letter to the Committee that "at LHC, patient decisions are made by the local caregiver and the patient's physician—reimbursement is not a factor to be considered," a number of examples illustrate that therapists and branch managers at LHC Group were pressured by supervisors to achieve a higher number of therapy visits.[80]

An e-mail written by Division Vice President of Home Based Operations Angie Begnaud on April 2, 2008 demonstrates a centralized push from LHC Group management to increase the number of therapy visits performed. According to the e-mail written by Begnaud, LHC Group President and Chief Operating Officer Donald Stelly held a conference call to:

> stress the urgency of the problem with LUPAs and downgrades, and also the need for our [Directors of Nursing] to communicate with the therapists the problem with projecting visits and not completing them. The therapist [sic] also need to look at increasing the number of therapy visits if warranted to move these patients into the higher therapy buckets. In looking at all 2008 episodes, the company has a 10% LUPA rate and a 10% therapy downgrade rate for a 20% adjustment rate. Don has asked for us to have all hands on deck to look at all open episodes. He also asked that all DONs and BMs report to the state director weekly on the number of LUPAs and

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[77] E-mail from Chairman and CEO Keith Myers, LHC Group, April 4, 2008, LHCGroup_00048299—LHCGROUP_00048300, *LHCGroup_00048299.

[78] E-mail from Division Vice President Angie Begnaud, January 18, 2008, LHCGROUP_00053618—LHCGROUP 00053619, *LHCGROUP_00053618.

[79] Therapy Practice in the Refined PPS Environment: Challenges and Opportunities, LHCGROUP 00047210, LHCGROUP 00047230, *LHCGROUP 00047230.

[80] LHC Group Letter to the Finance Committee, Re: Letter of Inquiry dated May 12, 2010, June 4, 2010.

> downgrades. The last thing that he requested was that by the end of this week, all DONs and BMs call all of the therapists that do work for them to re-educate them on the final rule and to stress the urgency of not having the downgrades, and the need to really provide the amount of therapy visits necessary to move those patients into the higher buckets. Presently on our RAP claims, 47% of our therapy patients are receiving 0–5 therapy visits. This cannot continue to happen and the therapists need to get back with the agency asap after evaluation to let them know how many therapy visits they will be doing.[81]

In another example, a top manager of LHC Group's agencies in Kentucky suggested increasing therapy utilization "to get more profitable." An October 22, 2009 e-mail from LHC Group Kentucky State Director of Operations Lana Smith to LHC Group employee Carolyn Cole asked, "Considerations to get more profitable: Would you be able to increase therapy utilization in improve case mix and Op Margin? [sic] Both of these would improved [sic] financials."[82]

An employee in West Tennessee encouraged staff to attend a teleconference "so that we can get the higher paying buckets FULL." In the e-mail, LHC Group DON/Administrator in West Tennessee, Kim Bradberry, encouraged staff to attend a "MANDATORY" teleconference called "Therapy in the PPS Final Rule." She wrote "In looking at SVP tools for each [West Tennessee] office yesterday, the greatest % of visits are in the dreaded 0–5 bucket for each office. Let's all make a point of attending this, so that we can get the higher paying buckets FULL . . . we want to be able to say our '20+ buckets runneth over'! :-)"[83]

Another LHC Group administrator based in Tennessee, Susan Sylvester, instructed branch managers:

> When speaking with your therapists about downcodes, please discuss front loading of visits. It appears that many of the patients begin to improve and decide to refuse the remainder of their therapy, go to outpatient, or are rehospitalized. The more therapy visits we've gotten in before that happens, the better off we are, as well as the patient. Obviously our goal is to improve the patient's overall condition and functionality, however if we are providing 5 therapy visits or less, we have incurred all of the expense of the therapy without any of the reimbursement. If the visits are frontloaded, ie 3w4, 2w4, 1w1, we may be able to get in enough visits early enough to complete (or nearly complete) our plan of care.[84]

On the subject of "discussions/emails about downcodes, LUPA's and therapy utilization over the past week or so," Susan Sylvester said, "This is a MAJOR push for Sr. Management at this time, as well as for all of us, in order to continue to operate successfully."[85]

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[81] E-mail from Angie Begnaud to Pam Wigglesworth, April 2, 2008, LHCGROUP_00009896.
[82] E-mail from Group Kentucky State Director of Operations Lana Smith to Pam Barnett, October, 22, 2009, LCHGROUP_00018983.
[83] E-mail from LHC Group DON/Amin Kim Bradberry, April 18, 2008, LHCGROUP_00014651—LHCGROUP_00014653, *LHCGROUP_00014651.
[84] Branch Manager Pamela Harris e-mail to Susan Sylvester, April 8, 2008, LHCGROUP_00014716—LHCGROUP_00014717, *LHCGROUP_00014716.
[85] *Id.*

An LHC Group branch manager who received these instructions reported a conversation with a company therapist in which the therapist agreed to "frontloading as well as going back after a couple of week [sic] to see if patients are following their exercise program or are functionally declining, in an attempt to raise the number of visits." [86]

The post-2007 therapy payment rules had an obvious effect on an LHC Group agency in West Virginia. The local agency manager wrote to Becky McCoy, the state director for Ohio/West Virginia, "[name redacted] now has an understanding of the therapy buckets. He now places his patient's [sic] in 6, 10, or 14 visit ranges." [87]

A July 8, 2009 e-mail from LHC employee Katy Lebauve to LHC Group employee Kimberly Gordon stated: "You have 20% in the 7–9 therapy bucket range. Please get with the therapists and have them reeval [sic] those to see if any can or need to be bumped up please." [88]

Additionally, LHC Group managers may have implicitly encouraged higher therapy utilization by discussing the higher revenue of some therapy thresholds. For example, the LHC Group Division Vice President Ammy Lee based in Lafayette, LA told an LHC branch manager in Guntersville, AL after reading the weekly report for December 1, 2009, "I see 19 patients in the 12–14 therapy bucket. Were you aware that there is an 18% difference in revenue between this bucket and the next highest one (15–16)?" [89]

Almost Family

Therapy Metrics

An examination of the therapy metrics suggests that the company was responsive to the incentive changes in the CMS payment model. As Figure 18 indicates, in 2007, 9.4 percent of Almost Family's therapy episodes received 10 visits while 3.2 percent of the therapy episodes received 9 visits. In 2008, the number of therapy episodes that received 10 visits dropped to 5.2 percent. Also from 2007 to 2008, the number of therapy episodes receiving 6 visits increased from 4.5 percent to 6 percent, and the number of therapy episodes receiving 14 visits increased from 4.6 percent to 6.1 percent.[90]

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[86] *Id.*

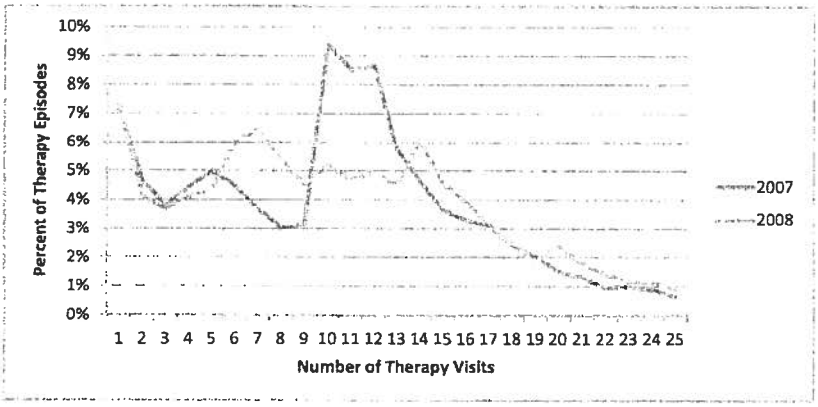
[87] E-mail from LHC Group Branch Manager Melissa Ayers to State Director Becky McCoy, October 20, 2008, LHCGROUP_00040048—LHCGROUP_00040049, *LHCGROUP_00040048.

[88] E-mail from Katy LaBauve to Kimberly Gordon, July 8, 2009, LHCGROUP_00050805.

[89] E-mail From LHC Group Division Vice President Home Based Operations to Area Sales Manager, December 2, 2009, LHCGROUP_00048771—LHCGROUP_00048774, *LHCGROUP_00048771.

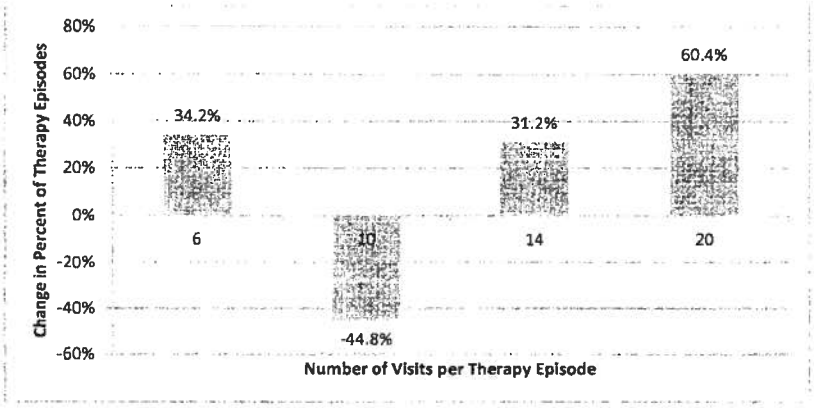
[90] Almost Family, Therapy Distribution.

Figure 18: Almost Family Distribution of Episodes with Therapy Visits, 2007 vs. 2008



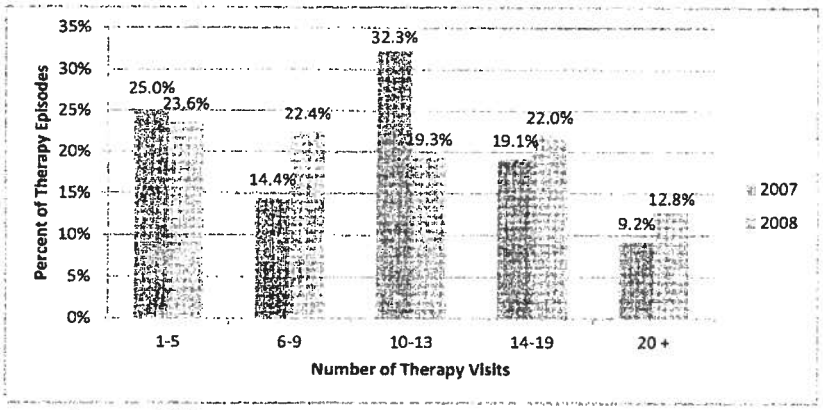
Source: Almost Family

Figure 19: Almost Family Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Almost Family

Figure 20: Almost Family Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Almost Family

Home health episodes with therapy reimbursements accounted for 75 percent of Almost Family's Medicare revenue in 2009 at $165,489,710. Almost Family's total Medicare revenue for 2009 was $218,011,583.[91] Medicare reimbursements consisted of 77 percent of Almost Family's revenue in 2009.[92]

The Committee notes Almost Family had a significant decrease in the percentage of patients receiving 10 therapy visits per episode from 2007 to 2008. At the same time, Almost Family increased the number of patients receiving 6, 14, and 20 therapy visits.[93] The change in the distribution of therapy visits performed by Almost Family after the implementation of the 2008 PPS rule represents a behavioral shift similar to that of other home health agencies within our investigation, some of which implemented aggressive, top-down programs explicitly instructing employees to target specific therapy visit thresholds. However, none of the documents provided to the Committee by Almost Family show that executives ever pushed therapists to target thresholds or pursue more profitable clinical regimens.

CMS Must Move Toward Taking Therapy Out of the Payment Model

Over the last 2 years CMS has taken several steps to address the overutilization of home therapy episodes.

In a CY 2011 final rule, CMS concluded from data analysis that the industry may be "padding" their treatment plans to reach the higher-paying therapy visit thresholds. Under the rule, CMS modified therapy coverage policies to require stronger documentation, with the intent to slow the growth of case-mix. Such modifications include periodic patient function assessments by qualified thera-

[91] Almost Family Letter, Medicare Reimbursements.
[92] Almost Family Annual Report 2010, page 6, *http://almostfamily.ir.edgar-online.com/EFX_dll/EDGARpro.dll?FetchFilingCONVPDF1?SessionID=A7jUF5M1mZimg3h&ID=7757385.*
[93] Almost Family Response to June 12, 2010 Request to Almost Family, Inc., June 4, 2011.

pists. The rule also requires thorough documentation of therapy progress with measurable outcomes.[94]

In the CY 2012 proposed rule released on July 5, 2011, CMS stated, "Our review of HH PPS utilization data shows a shift to an increased share of episodes with very high numbers of therapy visits. This shift was first observed in 2008 and it continued in 2009." CMS data also showed that, ". . . the share with 14 or more therapy visits continued to increase while the share of episodes with no therapy visits continued to decrease. The frequencies also indicate that the share of episodes with 20 or more therapy visits was 6 percent in 2009. This is a 50 percent increase from the share of episodes of 2007, when episodes with at least 20 therapy visits accounted for only 4 percent of episodes."[95]

Under the proposed rule, CMS plans to redistribute PPS dollars from high therapy payment groups to other payment groups including groups with little to no therapy. This change is being proposed as an attempt to discourage unnecessary utilization of therapy services.[96] The additional steps CMS has taken to crack down on "padding" of therapy episodes and the potentially unnecessary utilization of therapy services documented in this report are encouraging. While comprehensive change may take several years to implement, it appears CMS's home health PPS enhancements are moving in the right direction.

This investigation has highlighted the abrupt and dramatic responses the home health industry has taken to maximize reimbursement under both a 10-threshold model and a 6–14–20 therapy threshold model. Under the home health PPS, providers have broad discretion over the number of therapy visits to provide patients and therefore have control of the single-largest variable in determining reimbursement and overall margins.

This dynamic was highlighted in an e-mail from LHC Group CEO Keith Myers to senior executives throughout the firm:

> Sales incentives are driven by admissions × case mix, and the only way to get case mix up is to increase therapy utilization. . . . Take a look at the chart below. This shows you how much of an impact therapy has on case mix, and case mix is what determines revenue.[97]

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[94] Medicare Program, "Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices, Final Rule," *Federal Register* 75:221 (17 November 2010), p. 70372.

[95] Medicare Program, "Home Health Prospective Payment System Rate Update for Calendar Year 2012, Proposed Rule," *Federal Register* 76:133 (12 July 2011), p. 40988.

[96] *Id.*

[97] E-mail from Chairman and CEO Keith Myers, LHC Group, April 4, 2008, LHCGroup_00048299—LHCGROUP_00048300, *LHCGroup_00048299.

Total Therapy Visits	Average Case Mix	% of All Episodes
20+	3.05	2.6%
18-19	2.36	1.3%
16-17	2.22	3.1%
14-15	2.08	7.4%
11-13	1.77	6.1%
10	1.60	2.9%
7-9	1.38	4.1%
6	1.17	2.2%
0-5	.86	70.4%

Another e-mail from CEO Myers stated: "I think we can safely say that higher therapy utilization results in higher absolute margins and higher margins as a percentage of revenue under the current case mix weights."[98] This e-mail was based on an additional chart circulated at LHC Group that analyzed the payment changes made by CMS.

[Number] Therapy Visits	Average Reimbursement	Average Cost	Average Margin Per Episode	Average % Margin Per Episode
0-5	$1,900	$1,521	$378	19.93%
6	$2,617	$2,084	$532	20.34%
7-9	$3,057	$2,377	$680	22.26%
10	$3,493	$2,671	$821	23.52%
11-13	$3,831	$2,944	$886	23.14%
14-15	$4,418	$3,183	$1,234	27.94%
16-17	$4,725	$3,424	$1,301	27.54%
18-19	$5,091	$3,767	$1,324	26.01%
20+	$6,540	$4,648	$1,892	28.94%

MedPAC, in conjunction with the Urban Institute, is developing an alternative payment model that relies on patient characteristics rather than therapy utilization to determine reimbursement levels.[99] CMS should closely examine any approach that focuses on patient well-being and health characteristics, rather than the numerical utilization measures. Further, CMS should continue efforts to assess the efficiency and effectiveness of various post-acute care settings and the services they provide. This includes the Continuity Assessment Record and Evaluation (CARE) tool, a standardized patient assessment system intended to measure health outcomes of post-acute Medicare patients.[100]

The Committee also looks forward to receiving reports on future demonstration projects implemented by the 2010 Affordable Care Act, notably an alternative payment model pilot program for post-acute Medicare patients, which includes bundled payments; and the establishment of the Center for Medicare and Medicaid Innovation (CMI) which is charged with testing innovative payment and service delivery models to reduce program expenditures and en-

[98] E-mail from LHC Group CEO Keith Myers, May 29, 2009, LHCGROUP 00012744—LHCGROUP 00012746.
[99] MedPAC, "Report to Congress," March 2011.
[100] CMS, "Agency Information Collection Activities: Submission for OMB Review; Comment Request," *Federal Register* 72:217 (9 November 2007), p. 63612.

hance quality of care.[101] [102] We anticipate these programs will further shed light on the deficiencies within the PPS system and highlight new, innovative reimbursement methods that may encourage high-quality, patient-centered care, and discourage abuse of the Medicare program.

[101] Patient Protection and Affordable Care Act, Pub L. no. 111–148, § 3023, 124 Stat 401 (2010).
[102] Patient Protection and Affordable Care Act, § 3021, 124 Stat 389.

Exhibit (16)

D H E C

PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

CERTIFIED 91 7108 2133 3935 6155 6301

November 23, 2010

Mr. Neil L. Pruitt, Jr., Chairman and CEO
UHS-Pruitt Corporation
1626 Jeurgens Court
Norcross, Georgia 30093

RE: CO-10-12

Dear Mr. Pruitt:

Please find enclosed a signed copy of the executed Consent Order and Agreement regarding the above referenced action. This letter also serves to confirm receipt of the Civil Penalty payment in the amount of $20,995 for invoice PC06803-1.

Should you have any questions regarding the above information, please contact me at (803) 545-4200.

Sincerely,

Beverly Brandt

Beverly A. Brandt, MPH, Chief
Bureau of Health Facilities and Services Development

Enclosures: Invoice PC06803-1
Executed Consent Order

01033

D H E C

PROMOTE PROTECT PROSPER

South Carolina Department of Health and Environmental Control

INVOICE FOR SERVICES

Bureau of Financial Management / Sims/Aycock Building
2600 Bull St, Columbia, South Carolina 29201

Invoice No.
PC06803-1

Invoice To:
UNIHEALTH POST- ACUTE CARE - COLUMBIA

PO BOX 1210
TOCCOA, GA 30577-

Ship To:
S.C. DHEC
Attention: Bureau of Financial Management
2600 Bull Street
Columbia, South Carolina 29201

Date:	Terms:	Department Name	Order Filled By:
11/8/2010	**DUE UPON RECEIPT**	Planning and Programs	CURRYDSM

Description of Services: UNIHEALTH POST ACUTE CARE-COLUMBIA (SC-07-04) CONSENT ORDER. CO-10-12.

Qnty	Unit Description	Loc	Organ.	Fund	Account	Analytical	Unit Price	Amount
1	CONSENT ORDER CO-10-12. CK#556639 RCVD 11/4/10.	400	402011	534423	4571401	0000000	$20,995.00	$20,995.00
							Total:	$20,995.00

NOV - 4 2010

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Mailing Address _____

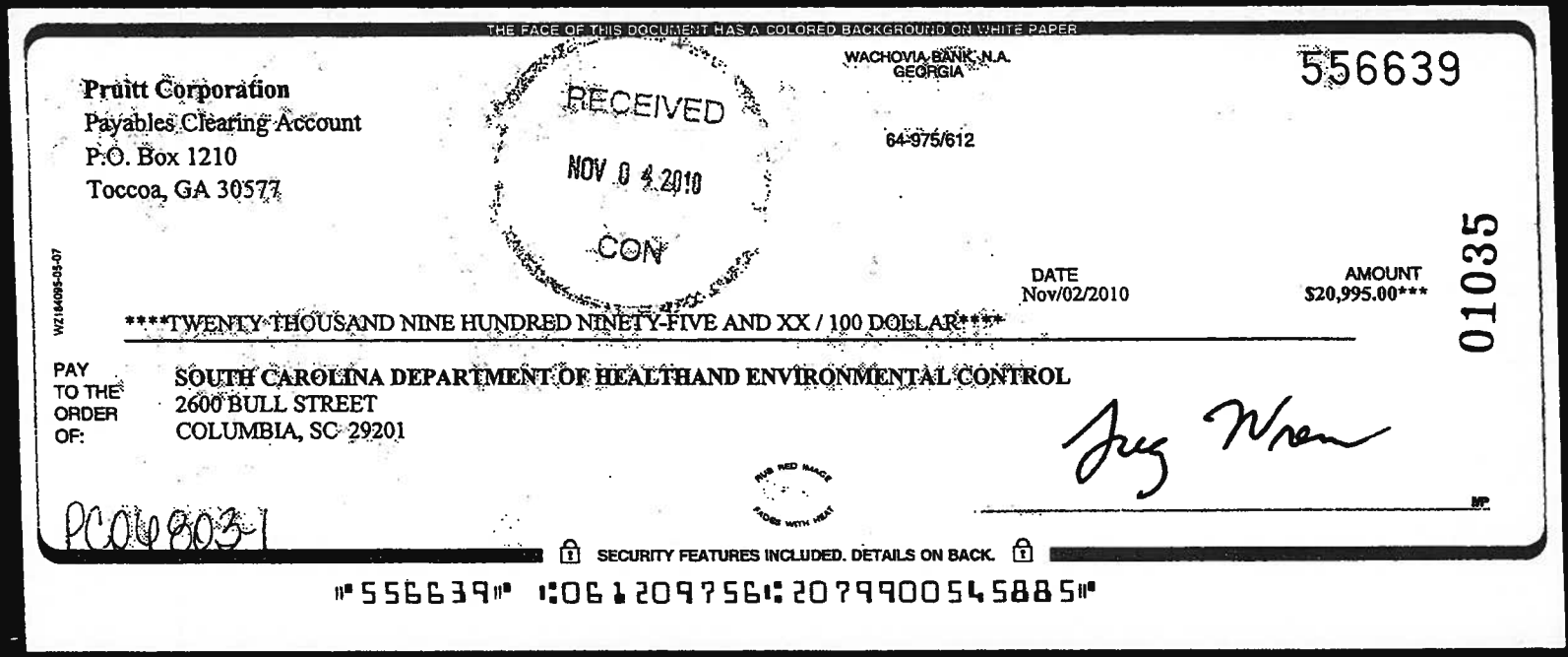
Master Card / Visa / Discover

Type of card (circle one) _____ Credit Card Number _____

Expiration Date _____ Signature _____

01034

Note: Make checks payable to South Carolina Department of Health and Environmental Control, remit to above address to the Attention of: Bureau of Financial Management



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Pruitt Corporation
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Toccoa, GA 30577

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GEORGIA

64-975/612

556639

01035

WZ184095-03-07

DATE
Nov/02/2010

AMOUNT
$20,995.00***

****TWENTY THOUSAND NINE HUNDRED NINETY-FIVE AND XX / 100 DOLLAR****

PAY TO THE ORDER OF:
SOUTH CAROLINA DEPARTMENT OF HEALTHAND ENVIRONMENTAL CONTROL
2600 BULL STREET
COLUMBIA, SC 29201

PCOW803-1

MP

SECURITY FEATURES INCLUDED. DETAILS ON BACK.

⑈556639⑈ ⑆061209756⑆ 20799005458 85⑈

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND	)	Before the South Carolina Department of Health and Environmental Control
In Reference:	)	**CONSENT ORDER AND AGREEMENT**
UniHealth Post –Acute Care - Columbia 2451 Forest Drive Columbia, SC 29204	)	**CO-10-12**
United Health Services of SC, Inc. 1626 Jeurgens Court Norcross, Georgia 30093	)	

The South Carolina Department of Health and Environmental Control ("Department") is the agency of the State of South Carolina responsible for administering S.C. Code Ann. § 44-7-110 *et seq.* (2002 and Supp. 2009), State Certification of Need and Health Facility Licensure Act, 24A S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services and S.C Code Ann. Regs. 61-17 (Supp. 2009) Standards for Licensing Nursing Homes. On August 24, 2010, the Department's Division of Health Licensing ("DHL") conducted an inspection that determined UniHealth Post-Acute Care-Columbia ("UPAC-Columbia") had exceeded its licensed bed capacity of one hundred seventy-one (171). At the time of the inspection, one hundred eighty-eight (188) nursing home beds were set up at the facility and the census was one hundred seventy-three (173) residents. Certificate of Need ("CON") SC-07-04, issued January 29, 2007, established one hundred twenty (120) beds at the The Oaks of Blythewood ("Oaks," now UniHealth Post-Acute Care-Blythewood, "UPAC-Blythewood"). This facility was created in part by transferring 86 beds from Carolina Health and Rehabilitation Center ("CHRC"), now known as UPAC-Columbia, which left a complement of one hundred seventy-one (171) beds remaining at UPAC-Columbia. UPAC-Columbia does not possess a valid CON for greater than one hundred seventy-one (171) nursing home beds. The parties have agreed to the issuance of this Consent Order and Agreement, to include the following Findings of Fact and Conclusions.

FINDINGS OF FACT

1. On January 29, 2007, CON SC-07-04 was issued to Oaks for "Construction of a one hundred twenty-three (123) bed nursing home to be known as The Oaks of Blythewood with a Medicaid Nursing Home Permit of twenty-one thousand nine hundred (21,900) Medicaid Patient days by transferring eighty-nine (89) existing nursing home beds from CHRC and adding thirty-four (34) nursing home beds; the existing CHRC will retain one hundred sixty-eight (168) nursing home beds and a Medicaid Nursing Home Permit of forty-seven thousand one hundred (47,100) Medicaid patient days."

2. On May 20, 2008, Scott Shull, Vice President of Planning & Development, UHS-Pruitt Corporation, requested a reduction in beds from one hundred twenty-three (123) beds to one hundred twenty (120) beds at Oaks, which resulted in the relocation of eighty-six (86) beds from CHRC instead of the initially approved eighty-nine (89) beds. The letter from Mr. Shull indicated that CHRC would retain a total of one hundred seventy-one (171) licensed nursing home beds.

3. On June 8, 2010, DHL received an "Application for License to Operate an Inpatient Care Facility" from UPAC-Blythewood for an Initial License for a nursing home with a total of one hundred twenty (120) beds.

4. On June 10, 2010, DHL received an "Application for License to Operate an Inpatient Care Facility" from UPAC-Columbia to change the number of licensed units from two hundred fifty-seven (257) to one hundred seventy-one (171).

5. On August 24, 2010, DHL performed an unannounced inspection at UPAC-Columbia. The inspection revealed several deficiencies with R.61-17, to include violation of Section 201.D

"Licensed Bed Capacity." At the time of the inspection, the facility was licensed for one hundred seventy-one (171) nursing home beds, but one hundred eighty-eight (188) nursing home beds were set up in the facility and the current census was one hundred seventy-three (173) residents. The report also indicated that CON SC-07-04 transferred eighty-six (86) nursing home beds from UPAC-Columbia to UPAC-Blythewood, bringing the licensed capacity at UPAC-Columbia to one hundred seventy-one (171) beds. The Department left a report with Brenda S. Hughes that indicated a "Plan of Correction" was due on September 8, 2010.

6. On September 3, 2010, Neil L. Pruitt, Jr., Chairman and CEO, UHS-Pruitt Corporation, met with Department staff to discuss the fact that UPAC-Columbia was operating at an occupancy level greater than its current license.

7. On September 7, 2010, Mr. Pruitt sent the Department a letter as a follow-up to the meeting of September 3, 2010. The letter indicated that the census at UPAC-Columbia was one hundred seventy-six (176) residents on August 20, 2010, they had been successful in finding comparable, alternate placements for the residents that exceeded the facility's licensed beds and "at the current time, we have a census of 170." The letter also stated "at no time did we ever service more patients than our original license of 189."

8. On August 26, 2010, DHL issued a license amended on August 20, 2010 to UPAC-Columbia for a "Nursing Home with a Maximum Capacity of 171 Nursing Home Beds." The cover letter for the license indicated: the reduction in licensed bed capacity from two hundred fifty-seven (257) to one hundred seventy-one (171) nursing home beds went info effect on August 20, 2010; the eighty-six (86) nursing home beds that were decreased at UPAC-Columbia became part of the one hundred twenty (120) bed licensed capacity at UPAC-Blythewood; and the actions

occurred simultaneously. The letter referenced CON SC-07-04 which provided for the construction of a one hundred twenty (120) bed skilled nursing home by transferring eighty-six (86) existing nursing home beds from CHRC (now known as UPAC-Columbia).

9. As of this date, the Department has not issued a CON to UPAC-Columbia to add eighteen (18) nursing home beds for a total of one hundred eighty-nine (189) nursing home beds; therefore, the current licensed bed capacity of one hundred seventy-one (171) beds has been exceeded and the facility has undertaken this activity prior to CON approval.

10. UPAC-Blythewood was not completed in accordance with the portion of the approved CON application that indicated CHRC would retain one hundred seventy-one (171) nursing home beds.

CONCLUSIONS

1. Article 3 from the "State Certification of Need and Health Facility Licensure Act", South Carolina Code Ann. Section 44-7-110 *et seq.*(2002 and Supp. 2009), authorizes the Department to require a Certificate of Need and licensure for nursing homes.

2. South Carolina Code Ann. Section 44-7-150 authorizes the Department to administer a Certificate of Need program.

3. South Carolina Code Ann. Section 44-7-260(A)(2) authorizes the Department to license nursing homes.

4. Section 102.1.b of S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services, requires that person or health care facility as defined in this Regulation must obtain a CON from the Department before undertaking a change in the existing bed complement through the addition of one or more beds.

5. Section 202.2(d)(4) S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services requires the applicant to furnish a written assurance that they "will cause the project to be completed in accordance with the Certificate of Need application."

6. Section 311 S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services requires that the Certificate of Need, if issued, is valid only for the project described in the application. Implementation of the project or operation of the facility that is not in accordance with the Certificate of Need application or conditions subsequently agreed to by the applicant and the Department may be considered a violation of this Regulation.

7. Section 607.5 S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services states that undertaking a project that is not in accordance with the approved application or conditions or amendments subsequently agreed to by the applicant and the Department may be considered a violation of this article.

8. Section 702 S.C. Code Ann. Regs. 61-15 (Supp. 2009), Certification of Need for Health Facilities and Services states that undertaking any activity requiring certificate of need review, as defined in Section 102 of these regulations, without prior approval of the Department evidenced by the issuance of a Certificate of Need shall be grounds for the denial, suspension, or revocation of a license, or other penalties, under the provisions of Sections 44-7-320 through 44-7-340 of the Code of Laws of South Carolina, as amended. Any violation of this regulation is subject to provisions set forth in the statute.

9. Section 201.D "Licensed Bed Capacity" of S.C. Code Ann. Regs. 61-17 (Supp. 2009) Standards for Licensing Nursing Homes, states that no facility that has been licensed for a set number of licensed beds, as identified on the face of the license, shall exceed the licensed bed

capacity. No facility shall establish new care or services or occupy additional beds or renovated space without first obtaining authorization from the Department.

10. South Carolina Code Ann. Section 44-7-320(A)(1)(a)(2002) authorizes the Department to assess a monetary penalty against a facility for violating a provision of the CON Act or departmental regulations.

11. The Department finds that a civil penalty should be assessed to United Health Services of SC, Inc. for its violation of S.C. Code Ann. Regs. 61-15 and S.C. Code Ann. Regs. 61-17 in an amount equal to twenty thousand nine hundred ninety five dollars ($20,995.00), which is based upon a private rate of $221 per day x 19 days of non-compliance (August 20- September 7) x 5 (five patients in excess of 171 licensed beds).

12. The Department has determined that the public interest would not be served by taking any other against United Health Services of SC, Inc.

THEREFORE, IT IS AGREED THAT

Pursuant to S.C. Code Ann. § 44-7-320 (2002) and with the consent of United Health Services of SC, Inc.:

1. United Health Services of SC, Inc. shall pay to the Department a Civil Penalty in the amount of twenty thousand nine hundred ninety-five dollars ($20,995.00) within thirty (30) days of receipt of the executed Consent Order.
2. United Health Services of SC, Inc. shall ensure that at no time will its facilities exceed their licensed bed capacity.

3. United Health Services of SC, Inc. shall ensure compliance with all applicable requirements of R.61-15 and R.61-17.

4. This Consent Order contains the entire agreement between the parties with respect to the resolution and settlement of the matters set forth herein. The parties are not relying upon any representations, promises, understanding, or agreements except as expressly set forth herein.

5. The parties understand that this Consent Order governs only the liability to the Department arising from the matters set forth herein.

6. United Health Services of SC, Inc. acknowledges that decisions cannot be made for pending or future Certificate of Need related projects, and any other decisions, licenses or registrations currently pending with the Department, unless the Consent Order is fully executed and the twenty thousand nine hundred ninety-five dollars ($20,995.00) civil penalty is paid in full.

For the South Carolina Department of Health and Environmental Control:

C. Earl Hunter Date 11-17-10

C. Earl Hunter, Commissioner
S.C. Department of Health and Environmental Control

Pamela M. Dukes Date 11/15/10

Pamela M. Dukes, Deputy Commissioner
Health Regulation Deputy Area

[signatures continue on following page]

01042

Nancy E. Maertens, Director
Division of Health Licensing

Date 11-16-10

Beverly A. Brandt, Chief
Bureau of Health Facilities and Services Development

Date 11-15-10

Ashley C. Biggers
Chief Counsel for Health Regulation

Date 11-16-10

For United Health Services of SC, Inc.:

Date 11/2/10

UHS PRUITT
CORPORATION
Committed to Caring

November 3, 2010

Ms. Beverly A. Brandt
Bureau of Health Facilities and Services Development
Health Regulation- SC DHEC
2600 Bull Street
Columbia, SC 29201

RE: UniHealth Post-Acute Care-Columbia (SC-07-04) – Consent order payment

Dear Ms. Brandt:

In response to Consent Order CO-10-12 issued September 29, 2010, please find enclosed check #556639 for the agreed upon civil penalty. We have been anticipating an invoice for the amount of $20,995.00 as indicated in previous correspondence, but to date have not received any such invoice. In a continued effort to be in full compliance with all appropriate regulations, I wanted to move forward with issuing payment, and to apologize again for the miscommunications that occurred.

According to your letter dated September 29th, once this penalty has been paid decisions on pending projects can be made by your office. We anticipate your confirmation of payment in full, and thank you for your time and efforts. Should you have any questions or require further information please do not hesitate to contact me.

With kindest regards, I am

Sincerely,

Nick Williams
Sr. Vice President of Corporate Development

Enclosure

NOV - 4 2010

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1626 Jeurgens Court • Norcross, Georgia 30093 • (770) 279-6200 • Fax: (770) 925-4619